Date: _____ Name: _____

DOB: _____ Acct: _____

Insurance: _____

Patient Health History and Information

Date: ___/___/___ **Age:** _____ **Height:** _____ **Weight:**_____ **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Sex: M F **Reason for Therapy:**_____

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown)**:**_____

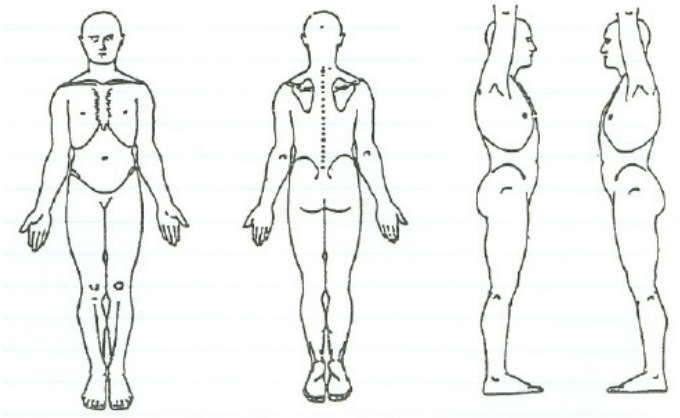
Date of injury or onset of symptoms: ___/___/___ **Recent surgery?** Yes No **Date:** ___/___/___ **Type:**_____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor)**:**_____

For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: _____ ___/___/___ Surgery: type:_____ ___/___/___ Other:_____ ___/___/___

Using the key below indicate on the body diagrams where your symptoms are located.
X=Pain //= Numbness
O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0 1 2 3 4 5 6 7 8 9 10
At worst:	0 1 2 3 4 5 6 7 8 9 10
At best:	0 1 2 3 4 5 6 7 8 9 10

Please describe your pain/symptoms

Constant Intermittent Increasing Decreasing Staying the same	
Sharp Dull Aching Burning Weakness Throbbing Other:_____	

Which side are we seeing you for?: Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity)_____

What makes your symptoms better? (i.e. heat, cold, rest, activity)_____

Please indicate your current limitations due to injury:

____ Sitting: _____	____Standing: _____	____Sleeping: _____	
____ Going from sit to stand	____ Walking _____	____ Lying down	____ Up/Down stairs
____ Reaching _____	____ Squatting	____ Bending	____ Looking overhead
____ Taking a deep breath	____ Swallowing	____ Talking / Chewing / Yawning / All (circle one)	
____ Turning head	____ Driving	____ Work	
____ Self care / Hygiene _____		____ Home activities _____	
____ Repetitive activities _____		____ Sports / Recreation _____	
____ Other:_____			

What are your goals for therapy?_____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes No		Unexplained weight change	Yes No	
Nausea / Vomiting	Yes No		Night sweats / pain	Yes No	
Numbness genital/anal area	Yes No		Problems with vision / hearing / speech	Yes No	
Dizziness / Fainting	Yes No		Difficulty with bowel/bladder function	Yes No	
Unexplained weakness	Yes No		Other:_____	Yes No	
Headaches	Yes No				

Who referred you to Physical Therapy? _____

Primary Physician:_____

How did you hear about MSSR Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

Date:_____ Name:_____

D.O.B._____ Patient Account _____
Insurance: _____

GENERAL HEALTH HISTORY:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No _____x/week

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Living Situation: Alone Spouse Family Others

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC (if you have one)**:**_____

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	Epilepsy/dizziness	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No	Other:_____	Self	Family	No

---

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: ___Yes ____No _____

_____

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

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Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of <u>prescription medication</u> (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

<u>Over the Counter medication</u> or <u>nutritional supplements</u>	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:		Patient updated:	Date:
Therapist reviewed:	Date:		Therapist reviewed:	Date:

MINNESOTA SPORT & SPINE REHABILITATION

AUTHORIZATION FOR TREATMENT: I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Minnesota Sport & Spine Rehab (MSSR) to provide such treatment. **Initials** _____

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to MSSR for services furnished to me by MSSR . I authorize to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL THERAPY SERVICES RENDERED.** **Initials** _____

RECORD RELEASE: I hereby authorize MSSR to release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **Initials** _____

Please also release medical information regarding my physical therapy care to the following individual(s): (i.e., family members, coaches, trainers, etc.). It is not necessary to list physicians or insurance companies here.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

HIPAA PRIVACY POLICY: I have been provided a copy of the HIPAA Privacy Policy for review and know that if I would like a copy of it to keep, I have requested one. **Initials** _____

CANCEL/NO SHOW POLICY: I have read and understand MSSR's No Show Policy and know that if I would like a copy of it to keep, I have requested one.

Initials _____

I recognize that MSSR has contacted my insurance company regarding physical therapy benefits. However, I understand and acknowledge that all benefits quoted by my insurance are a general outline of coverage, not a guarantee of payment and that I am responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

Patient's Printed Name: _____

_____ _____

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

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

REQUIRED SIGNATURE (UPDATE ANNUALLY)

****

MEDICARE PATIENTS ONLY:

1. Are you currently receiving any services from a home health care agency, transitional care facility, or nursing home?: **Yes ☐ No ☐** (If yes, we **cannot treat you today** as Medicare will not pay for our services while you receive any of the above).
2. Have you received any services in the past 30 days from a home health care agency, transitional care facility or nursing home? **Yes ☐ No ☐**

THERAPY PARTNERS

MINNESOTA SPORT AND SPINE REHABILITATION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: (Print) _____

Date of Birth: _____

I am requesting a copy of my physical therapy records be sent to:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip:_____

Concerning my treatment dates from: _____ to _____

Patient's Signature: _____
(Under 18 parent or guardian must sign)

**Date: _____

**This authorization is good for one year from the date of signature.

14000 NICOLLET AVENUE • SUITE 200 • BURNSVILLE, MN 55337 • 952-892-6777 • FAX 952-892-0792

An Associate of Therapy Partners, Inc.

NOTICE OF PRIVACY PRACTICE

We Care About Your Privacy

To Our Patients

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to therapists, doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized, or at another provider's office.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Use and disclosure of your health information in certain special circumstances

The following special circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To Federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to the clinic manager.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the clinic manager.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact the clinic manager.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the clinic manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you would like a copy of our privacy practices to keep, please ask our staff for one.

An Associate of Therapy Partners, Inc.

MSSR's CANCEL/NO SHOW POLICY: HOW IT AFFECTS YOU

Thank you for choosing Minnesota Sport & Spine Rehabilitation (MSSR) as your physical therapy provider.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule the time for another patient. Canceling an appointment with short notice or not showing up for an appointment, takes up clinic time that could benefit another person.

You will be charged $30 if you do not show up for your scheduled appointment.

"No showing" for three appointments over the course of treatment will, unfortunately, limit your ability to schedule advanced appointments and may result in allowing same day scheduling only.

If you "no show" for an appointment you will need to call to confirm any future appointments that are scheduled or your subsequent appointments may be cancelled.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this. If you know you are going to have a difficult time making your appointments, please discuss this with your therapist. We will try to accommodate your needs. Thank you.