PATIENT REGISTRATION

PATIENT INFORMATION			
PATIENT NAME (FIRST, MIDDLE, LAST)			HOME PHONE
HOME ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER (if needed for insurance)	DATE OF BIRTH	SEX	MARITAL STATUS
REFERRING PHYSICIAN		PRIMARY PHYSICIAN	
PRIMARY INSURANCE INFORMATION			
INSURANCE COMPANY			PHONE/ADJUSTOR NAME
WORK COMP/AUTO INSURANCE (CITY, STATE, ZIP)			
GROUP/CLAIM NUMBER	ID OR POLICY NUMBER		INJURY DATE
SECONDARY INSURANCE INFORMATION			
INSURANCE COMPANY			
GROUP NUMBER	ID OR POLICY NUMBER		

PATIENT AUTHORIZATION I hereby consent to physical therapy treatment by Select Therapy and further assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Select Therapy and also authorize the release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I also understand that in the event my account becomes 30 days past due, finance charges will be applied to my outstanding balance at the rate of 1% monthly. If my account goes to collections, I will be financially responsible for all debt collection fees.

Signature of Patient/Guardian/Responsible Party:

____ Date: ____________

By signing below, I am acknowledging that Select Therapy, Inc presented to me a copy of the HIPPA Privacy Act this day:

Name: ______________________________ Date: __________

By signing below, I am acknowledging that Select Therapy, Inc. presented me a copy of their Cancellation/No Show Policy on this date. If I choose not to abide by this policy I consent to pay a $25 penalty charge:

Name: Date:

Medical History and Information

Date:____________ **Name:** ______________________________ **Sex:** M F **Age:** _____

E-mail address: ______________________ **(for office use only)**

Dominant hand: R L

Reason for Therapy: ____

How did the injury occur (ie: fall, activity, work, auto):________________________________

Date of injury/onset of symptoms: ____________ **Recent surgery?** Y N **Date:** _________

Type of surgery: _______________________

Please list any treatment (if any) you have received for this condition (ie: therapy, chiropractor)
____

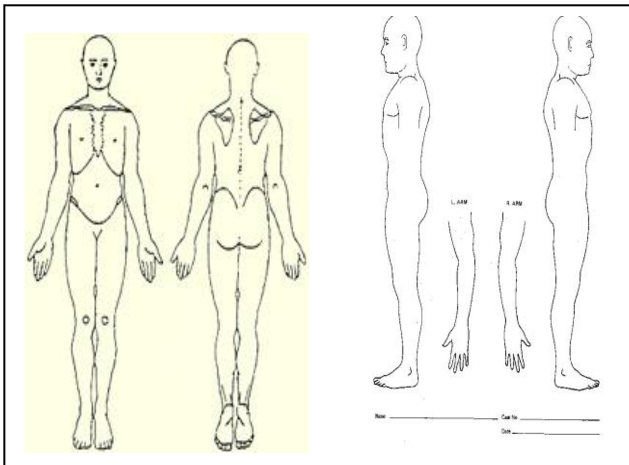
Have you received any of the following tests: None X-ray ________ MRI/CT scan ________

Injection: type: __________ ________ Surgery: type: ___________ ________ Other:___________
____

Using the key below indicate on the body diagrams where your symptoms are located.

O=Numbness
X=Tingling **//=Pain**

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



At present:
At worst:
At best:

Please describe your pain/symptoms

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

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

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

Have you ever been diagnosed with any of the following (please mark an "x" next to those that apply):

___Allergies/asthma
___Cancer
___High blood pressure
___Heart trouble/angina
___Diabetes
___Stroke
___Osteoporosis
___Osteoarthritis
___Rheumatoid arthritis
___Depression
___Headaches
___Kidney problems
___Thyroid problems
___Epilepsy/dizziness
___Tuberculosis
___Anemia/blood disorder
___Multiple Sclerosis
___Circular/vascular problems
___Chemical dependency
___Pacemaker/metal implants
___AIDS/HIV
___Hepatitis

__Bladder/bowel problems __Other: _________
Please list prescription/over the counter medications you are currently taking:
____

Are you a DNR (do not resuscitate) or DNI (do not intubate) patient? Y/N If yes, which one___________

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

Fever/ Chills Y N
Nausea/ Vomiting Y N
Numbness genital/anal area Y N
Dizziness/ Fainting Y N
Unexplained weakness Y N
Headaches Y N

How do you feel in the morning? ____________________
How do you feel in the afternoon? ___________________
How do you feel at night? _________________________
How do you feel in the evening? ____________________

Please rate your overall health: Excellent Good Average Poor

Do you exercise? Y N ______x/week
Do you smoke? Y N
Do you drink caffeinated beverages? Y N _____/week

What is your occupation/job title: __________________ Self Student Full-time Part-time Retired Unemployed

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): _____________

Please indicate your current limitations due to injury:
__Sitting __Squatting
__Going from sit to stand __Sleeping
__Reaching __Bending
__Turning head __Up/Down stairs
__Standing __Looking overhead
__Walking __Repetitive activities_____________
__Home activities _________ __Other: __________________

What are your goals for therapy? ____

Who referred you to Physical Therapy? ________________

Primary Physician: ______________________

Please list anything else that you would like us to know about you:
____

Patient signature: _____________________ Date __________

Therapist signature:___________________ Date __________

Select Therapy Cancel/No Show Policy

Thank you for choosing Select Therapy, Inc as your physical therapy provider.

Our facility is focused on helping you meet your goals of therapy. In order for our facility to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program, in hopes of quicker recovery and better treatment outcomes.

We are concerned for your progress in treatment, as well as your health; therefore we understand there may be unforeseen circumstances in which you may be unable to make your scheduled appointment. If this occurs, please contact our facility as soon as you can so we may reschedule another time for you, and to make the time available for another patient who would like to be scheduled. Canceling an appointment with little notice or failing to attend takes up clinic time that would be beneficial to other patients.

In an effort to enforce this policy, you will be charge $25 if you cancel an appointment less than 24 hours before your appointment time, or if you fail to show. This policy is waived **only** on your first missed appointment.

Canceling or "no showing" for more than three appointments may result in same day scheduling, restricting your ability to schedule appointments in advance from that point forward.

Your process to recovery is very important to us 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 do our best to accommodate your needs.

If you have any questions or concerns, please feel free to ask.

Thank you!

Select Therapy Staff

NOTICE OF PRIVACY PRACTICES

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

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment **includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.**

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder or to inform you of our other health-related products and services.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions
You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact
If you would like more information about our privacy practices or to file a complaint you may contact:

Trevor Harting
Privacy Officer
Select Therapy
14884 Kirkwood Drive
Baxter, Minnesota 56425
218-824-5027

Effective Date: This Notice will take effect on August 11, 2003.

By signing below, I am acknowledging that this notice was presented to me this day:

Name: ______________________________ Date: __________