WELCOME TO SUPERIOR PHYSICAL THERAPY

Please help us serve you better by taking a few minutes to provide the following information PLEASE PRINT

Your physician has prescribed a series of therapy treatments that are medically necessary for you to get the maximum benefit from your rehabilitation program. Please attend all appointments so that your experience here can be a most successful one.

PATIENT INFORMATION

Today's Date	**First Name**	**Middle Name/Initial**	**Last Name**
Nickname	**Gender** *Circle One* Male Female	**Date of Birth**	**Student** *Circle One* Full Part Not a Student
Marital Status *Circle One* Married Single	**Social Security Number**	**Patient Employer**	**Work Phone Number**
Home Phone Number	**Cell Phone Number**	**E-Mail Address**	

Mailing Address	**City**	**State**	**Zip Code**
Physical Address	**City**	**State**	**Zip Code**

If Patient is minor, name of Parent or Guardian	**Phone Number(s)**
Referring Doctor	**Primary Care Physician**

RESPONSIBLE PARTY

Last Name	**First Name**	**Middle Name/Initial**	**Social Security Number**
Patient's Relationship to Responsible Party *Circle One* Self Spouse Child Other	**Date of Birth**	**Driver's License/State Identification** State: Number:	

Mailing Address	**City**	**State**	**Zip Code**
Physical Address	**City**	**State**	**Zip Code**

Home Telephone Number	**Cell Phone Number**	**E-Mail Address**
Employer		**Phone Number**

INSURANCE INFORMATION *Please ensure that we get a copy of your insurance card(s)*

Primary Insurance

Insured's Last Name	**First Name**	**Middle Name/Initial**	**Patient's Relationship to Insured** *Circle One* Self Spouse Child Other
Social Security Number	**Date of Birth**	**Sex** *Circle One* Male Female	**Phone Number**
Employer			**Phone Number**
Primary Insurance Company			**ID #**
Address			**Group #**
City	**State**	**Zip Code**	**Policy #**

Secondary Insurance

Insured's Last Name	**First Name**	**Middle Name/Initial**	**Patient's Relationship to Insured** *Circle One* Self Spouse Child Other
Social Security Number	**Date of Birth**	**Sex** *Circle One* Male Female	**Phone Number**
Employer			**Phone Number**
Secondary Insurance Company			**ID #**
Address			**Group #**
City	**State**	**Zip Code**	**Policy #**

Please continue →

REASON FOR TREATMENT

Related Cause *Circle One*:

Auto Accident Fall Abuse Another Party Responsible Employment Injury

Sports Injury Surgery Other Accident None of the Above

Date of injury/first symptom:

How did Injury occur / symptom(s) begin?

At what location did injury occur?	**Body area of injury symptom(s):**

If An Accident:

Name of Employer/Third Party	**Phone Number & Name of Contact Person**
Name & Phone Number of Insurance Carrier/Company	**Name and extension number of Agent or Adjuster**
Claim#	**State in which Injury occurred**

EMERGENCY INFORMATION

Person to contact in case of Emergency	**Relationship to Patient**	**Phone Number(s)**	
Address	**City**	**State**	**Zip**

MEDICAL INFORMATION

Medical History: *If you have ever had a listed condition in the past please check it in the **PAST** column. If you are presently troubled by a particular condition, check in the **PRESENT** column. The information you provide concerning the past and present conditions and diseases assists your therapist in more thoroughly understanding you state of health.*

PAST	**PRESENT**		**PAST**	**PRESENT**	
□	□	High Blood Pressure	□	□	Arthritis
□	□	Angina	□	□	Pregnancy
□	□	Heart Attack	□	□	Pacemaker
□	□	Stroke	□	□	Joint Replacement
□	□	Asthma	□	□	Heart Disease
□	□	HIV/AIDS	□	□	Kidney Disease
□	□	Cancer Location:_____	□	□	Emphysema/Bronchitis
□	□	Tumor	□	□	Depression
□	□	Systemic Lupus	□	□	Tuberculosis
□	□	Hepatitis	□	□	Allergies
□	□	Epilepsy	□	□	Tobacco Packs/Day:_____
□	□	Diabetes	□	□	Fracture or Suspected Fracture
□	□	Rheumatoid Arthritis	□	□	Immunosupression
□	□	Traumatic Brain Injury	□	□	Obesity
□	□	Cauda Equina Syndrome	□	□	Fibromyalgia
		Current Infection _____			

Other:

HEIGHT: _____ **WEIGHT:** _____

What do you hope to accomplish during therapy?

HOW DID YOU FIND OUT ABOUT US?

Circle One: Internet Sports/School Programs Phone Book

Gold's Gym Coupon Word of Mouth Doctor Other: _____

CONSENT TO TREATMENT: I give my informed consent for any provider of Superior Physical Therapy and medically licensed or trained staff members to perform necessary treatment for me or the above listed minor child in my care.

Patient Signature *Date*

Parent/Guardian Signature *Date*

Bart McDonald, MPT
Melissa Merrill, DPT
Emilie Peterson, DPT
Andrew Goode, DPT
Barbara K. Peterson, OTR/L

Financial Policy

BASIC POLICY: As the patient, you are responsible for all of your medical bills in our office. It is also your responsibility to know your insurance contract benefits, assure collection of insurance payments to us, and negotiate disputed claims with your insurance company. We do not get involved in divorces/disputes or settlement arrangements.

IF YOU DO NOT HAVE INSURANCE: Our policy requires payment in full today. If you do not have insurance and cannot pay in full today you will need to meet with our Patient Relations Specialist and apply for CareCredit.

IF YOU DO HAVE INSURANCE: Your co-pay or co-insurance is due at the time of service. We will bill your insurance provider electronically where available. Please present your insurance card(s) to the receptionist at the time of your appointment.

REFERRALS: You are responsible to bring a referral from Indian Health Services or your appointment will need to be rescheduled.

WORKMAN'S COMPENSATION: If you are not compliant with your orders, your claim may be denied and you may be responsible for the entire bill. In the event that it is determined by the Worker's Compensation board that the illness or injury is not a result of a compensable Worker's Compensation case, we will bill your private insurance. The balance will be your responsibility. Please provide your personal health insurance to be held on file.

LIABILITY: If you request that we bill a 3rd party insurance secondary to a personal injury, you are required to make $25.00 payments per visit and sign a medical lien form guaranteeing Superior Physical Therapy payment for services at the time of your settlement. If pending settlement from an insurance company or attorney, monthly payments are required until a settlement is received.

MINOR PATIENTS: The parents, guardians, or adult accompanying a minor are responsible for full payment.

REJECTED CLAIMS: If your insurance company rejects your claims, or they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full after your insurance payment, please contact our business office to apply for CareCredit.

FORMS OF PAYMENT: We accept payments in cash, check, money order, Visa, MasterCard, Discover and CareCredit. We also accept post-dated checks.

DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our collection manager. If satisfactory arrangements for payment are not made, the account will be submitted to a collection agency.

MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance.

IF YOU HAVE ANY QUESTIONS PLEASE CALL OUR OFFICE AT 208-233-2248.
By signing below you signify that you have read, understand, and agree to this Financial Policy.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: _____

Bart McDonald, MPT
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Andrew Goode, DPT
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To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given in two sequential days.)

- There is a $25 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Interviewer Signature Date

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MEDICATIONS LIST

This list is to include the name of the medication, the dosage, the frequency and the way it is administered (i.e. oral, cream, IV, etc.). This includes over the counter, herbal, supplemental and prescriptions. Please be sure to let us know as you have any changes to your medications list.
Patient Name: _____ Date:_____

Name of Medication	Dosage	Frequency	Administered
Vitamin C	*1000 mg*	*Once Daily*	*Oral Tablet*

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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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Camille Gilbert
Phone:	208-233-2248
Address:	1800 Flandro Drive, Suite 190 Pocatello, ID 83202
E-mail:	cgilbert.spt@gmail.com

8. Effective Date. This Notice is effective September 1, 2013.

Bart McDonald, MPT
Melissa Merrill, DPT
Emilie Peterson, DPT
Andrew Goode, DPT
Barbara K. Peterson, OTR/L

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed a copy of the Superior Physical Therapy Notice of Privacy Practices. I understand that Superior Physical Therapy has the right to change its Notice of Privacy Practices form time to time and that I may contact Superior Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.

_____
Patient Name (please print)

_____
Signature of Patient, Legal Guardian, or Legal Representative

_____
Relationship to Patient

_____
Date

_____

FOR OFFICE USE ONLY

I have attempted to obtain the patient's signature on this form, but was not able to for the following reason:

_____

_____

_____

_____

_____

Initials: _____ Date: _____

Assessment Testing Screening Tool

Patient Name: _____ Date: _____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what assessment tests* might be appropriate for you.

Please check all that apply:

	Low Back Pain		*Weakness in the arms*		*Diagnosed with diabetes*
	Numbness in the Legs		*Weakness in the hands*		*Diagnosed with neuropathy*
	Neck Pain		*Weakness in the legs*		*Dizziness / Vertigo*
	Numbness in the arms		*Overall Muscle Weakness*		*Headaches*
	Numbness/Tingling in the hands		*Loss of sensation or decreased sensation in hands*		*History of Falls due to Dizziness or Unsteady gait*
	Numbness/Tingling in the feet		*Loss of sensation or decreased sensation in feet*		*Hypertension or hypotension*
	Burning Sensation		*Radiating pain in arms*		*Blurred Vision*
	Sensation of pins & needles		*Radiating pain in the legs*		*Hearing problems*

Patient Signature: _____

*Electromyography/Nerve Conduction Studies, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.

For office use only: PT _____ Y ☐ N☐ Why _____

❑ Rule out Cervical Radiculopathy

❑ Rule out Lumbar Radiculopathy

❑ Rule out Peripheral Nerve Entrapment

❑ Rule out Neuropathy

❑ Objectify a baseline test and retest for improvement gained from conservative management for PT