Superior Physical Therapy
Spine & Sports Center

Pocatello: 1800 Flandro Dr Ste 190, Pocatello, ID 83202
Phone: 208-233-2248, Fax 208-233-0219
Idaho Falls: 3345 Potomac Way, Idaho Falls, ID 83404
Phone: 208-417-0090, Fax: 208-417-0092

Please complete the following:

Today's Date:					
LAST NAME:		**FIRST NAME:**		**MI:**	**Height:**
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**	**Weight:**	**Referring Provider:**		
Address:			**City:**		**State:**
Phone:					
Emergency Contact Name:			**Emergency Contact Phone:**		
Insurance:					
ID#:			**Group #:**		

CONSENT for EMG Testing

I understand that I am going to undergo an electromyography (nerve conduction test). I agree to provide an accurate health history and statement of my physical abilities. I understand that the test may be uncomfortable and may cause some bruising later on. I also understand that I may need to return for an additional visit, depending on findings today.

_____ _____
Signature Date

_____ _____
Witness Date

Patient Name: _____ Date: _____

*__PLEASE COMPLETE BOTH SIDES OF THIS FORM__

Present Status:

Please describe your symptoms (i.e. pain, numbness, burning, tingling, coldness, weakness, etc.)

_____

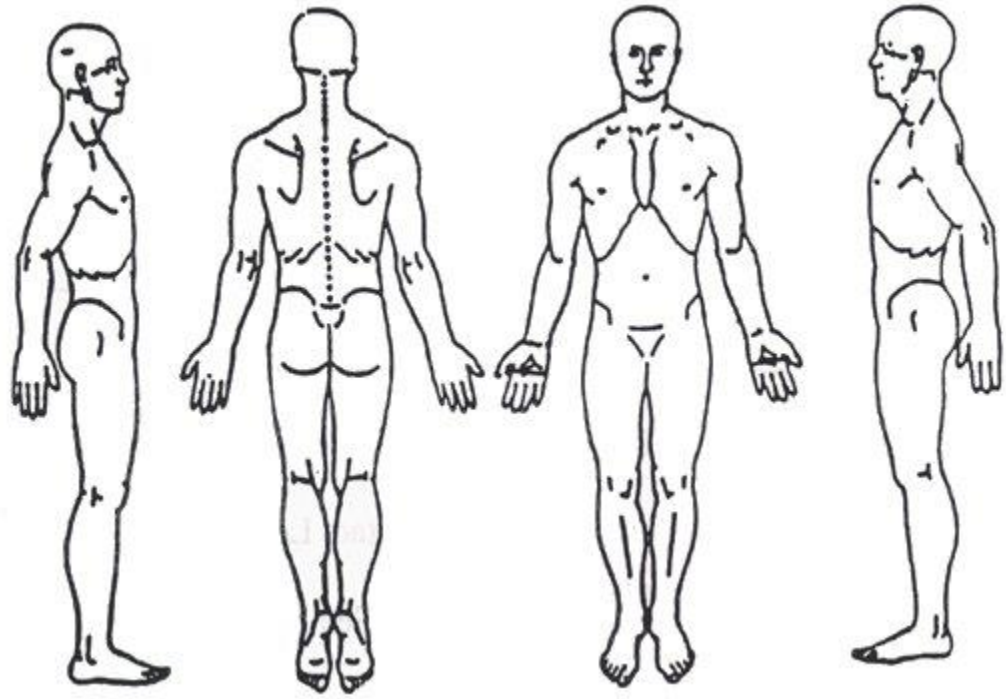
When did your symptoms begin? _____

How frequently do you have your symptoms?
□ Rarely (less than 10% of the day) □ Occasionally (11-25%) □ Intermittently (26-50%)
□ Frequently (51-75%) □ Constantly (76-100%)

Do you have a history of falls? □ Yes □ No Do you drop things often? □ Yes □ No

Do your symptoms get better or worse at night? _____

Please mark on the following diagrams where you have your symptoms:



Medical History:

Do you have a history of the following medical conditions? (Check all that apply.)

□ Heart Condition □ Coronary Artery Disease □ Peripheral Artery Disease □ Diabetes

□ Pacemaker □ High Blood Pressure □ High Cholesterol □ Thyroid Disorder □ Stroke / CVA

□ Cancer □ Chemotherapy □ Radiation Therapy □ Connective Tissue Disease

□ Asthma □ Neck pain □ Lower back pain □ Disc Herniations □ Arthritis

□ Stenosis □ Neuropathy □ Alcoholism □ Drug Use □ HIV / AIDS □ Hepatitis

□ Other _____

Surgical History:

Do you have a history of the following surgeries? (Check all that apply.)

□ Back Surgery □ Neck Surgery □ Joint Replacement □ Amputation

□ CABG / Heart Surgery □ Angioplasty □ Removal of Mass / Cancer □ Other _____

Imaging:

Have you have any imaging within the last year? □ Yes □ No Type: □ X-Ray □MRI □ CT

Body part _____

Your understanding of the findings: _____

Review of Systems:

Do you experience any of the following symptoms? (Check all that apply.)

□ fever, □ chills, □ weight gain, □ weight loss, □ fatigue, □ lack of appetite, □ headache,

□ dizziness, □ fainting, □ shortness of breath, □ chronic cough, □ chest pain, □ palpitations,

□ heartburn, □ abdominal pain or bleeding, □ joint pains or arthritis, □ balance or

coordination problems, □ bladder or bowel incontinence, □ bleeding disorders or anemia,

□ depression or anxiety.

Are you a smoker? □ Yes □ No

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*

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 Billing Specialist for more information on additional options.

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.

IHS REFERRALS: You are responsible to bring the authorization from the PRC department 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 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. Our Billing Specialist may call you for that arrangement.

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, you are responsible to pay the balance in full upon receipt of your statement. If you cannot pay in full after your insurance payment, please contact our billing office at 208-233-2248 to make other arrangements.

FORMS OF PAYMENT: We accept payments in cash, check, money order, Visa, MasterCard, Discover, American Express, and CareCredit.

DELINQUENT ACCOUNTS: If your account is delinquent over 60 days we will attempt to call you. If satisfactory arrangements for payment are not made, the account will be submitted to a collection agency after 90 days.

MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full.

IF YOU HAVE ANY QUESTIONS PLEASE CALL OUR OFFICE AT 208-233-2248.

By signing below you acknowledge that you have read, understand, and agree to this Financial Policy.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: _____

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: _____