



Welcome to NorthStar Physical Therapy!

Please Fill Out the Information as Complete as Possible

Patient

Patient's Full Name: _____ Age: _____ Birth Date: _____
Home Phone: _____ Work Phone: _____ Social Security#: _____
Address: _____
E-Mail Address: _____ Spouse or Guardian's Name: _____

Insurance (please provide a copy of your cards)

Primary Insurance: _____ Phone: _____
Policy Holder Name: _____ Group#: _____
MVA or Work Comp Claim #: _____
Secondary Insurance: _____ Phone: _____
Policy Holder Name: _____ Group#: _____

Responsible Payer

Responsible Payer Name: _____ Phone: _____ Birth Date: _____
Address: _____ Social Security #: _____
Employer: _____ Phone: _____
Address: _____ Occupation: _____

Emergency Contact

Name: _____ Phone Number: _____
Relationship: _____

Physicians

Primary Physician: _____ Referring Physician: _____
Phone: _____ Phone: _____

Referral Source (Please mark all that apply)

Doctor:___ Newspaper:___ Phone Book:___ Website:___ Family/Friend:___ Drive-by:___ Other:_____

How can you be reached?

Home Phone: _____ Cell phone: _____ Work phone: _____ Other: _____
May we leave a message at these numbers on a machine or with the person who answers? Yes/No



MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: M/F

Diagnosis/Surgery: _____

When and how did your problem begin? _____

Current Symptoms: _____

Have you had this problem before? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had any diagnostic tests recently? (ie x-rays, MRI, CT scan, etc...) _____

What are your expectations from therapy? _____

Please List all prescription and non-prescription medications you are taking: _____

Are you allergic to any medications? (please list) _____

Medical History: _____

Surgical History: _____

Do you normally work outside your home? _____ If yes, are you currently working? _____

Are you able to complete all work duties? _____ If no, please explain: _____

Any limitations around your home? (ie care of dependents, laundry, cooking, driving, cleaning, etc...) _____



CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Consent for Treatment: I, the undersigned, do hereby agree and give consent to NorthStar Physical Therapy to perform a physical therapy evaluation and treatment techniques as required to appropriately rehabilitate my therapy related condition.

Financial Consent: I agree to pay all amounts due on my account for physical therapy treatments provided by NorthStar. These amounts shall be determined by charges fixed by NorthStar Physical Therapy for outpatient physical therapy services. Copies of all charges and costs may be obtained on request. I understand NorthStar will submit my bill to my insurance or other third party payers but I am ultimately responsible for payment of my entire account if any denial occurs. I understand if I have a co-pay it is due at time of service and I may be required to make estimated payments for my portion of the bill. I understand that it is my sole responsibility to be aware of my insurance benefits and coverage and not NorthStar Physical Therapy's. If it becomes necessary to refer this account to an attorney for collection, I agree to pay the reasonable attorney's fees and collection costs.

Release of Information: I authorize NorthStar Physical Therapy to release all information necessary, including medical records, to secure payment for care they provided. Information may be disclosed to any party or organization responsible for all or part of my therapy charges, as well as a collection agency when deemed necessary. All or any of my medical records may be released to other health care providers when required to provide complete care.

Assignment of Benefits: I, the undersigned, voluntarily assign NorthStar Physical Therapy all medical benefits to which I am entitled for physical therapy services provided. I authorize payment directly to NorthStar Physical Therapy.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND MY FINANCIAL OBLIGATIONS.

Signed (patient/guardian): _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I received NorthStar Physical Therapy's Notice of Privacy Practice.

Signed (patient/guardian): _____ Date: _____



NOTICE OF PRIVACY PRACTICES

NorthStar Physical Therapy is required by law to maintain the privacy of your health information; give you notice of our legal duties and privacy practices with respect to your health information; and follow the terms of this notice. This notice will tell you about the ways in which we may use and disclose your health information in NorthStar Physical Therapy and with other entities. It also describes your rights regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician, or other health care personnel who have a legitimate need for such information in order to take care of you. We may disclose your health information to family members or friends, guardians, or personal representatives who are involved with your medical care. We may use or disclose your health information to provide you with appointment reminders.

FOR PAYMENT: We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, and claims management. We may also give information to other third parties or individuals who are responsible for payment for your health care.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

JUDICIAL or ADMINISTRATIVE PROCEEDING: We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil or criminal proceedings, or other lawful process.

LAW ENFORCEMENT: We may release your health information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons, or similar legal process.

Regarding a victim or death of a victim of a crime in limited circumstances.

In emergency circumstances to report a crime.

WORKERS' COMPENSATION: We may release your health information for workers' compensation benefits or to similar programs that provide benefits for work-related injuries or illness.

TO AVERT a SERIOUS THREAT to HEALTH or SAFETY: We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

NATIONAL SECURITY: We may disclose your health information to federal officials for national security activities and for the protection of the President and other Heads of State.

MILITARY and VETERANS: If you are a member of the armed forces, we may release your health information as required by military command authorities.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

RIGHT to INSPECT and COPY: You have the right to inspect and copy your health information including your medical or billing records, and any other records that may be used to make decisions about your care.

RIGHT to AMEND: You have the right to request an amendment to your health information that you believe is incorrect or incomplete. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

RIGHT to an ACCOUNTING of DISCLOSURES: We are required to maintain a list of disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that were not subject to your written authorization.

RIGHT to REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment or payment. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend. We are not required to agree to your request. However, if we do agree, we will comply unless the information is needed to provide you with emergency treatment.

RIGHT to REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. Your request must specify how or where you wish to be contacted and must be in writing.

COMPLAINTS: You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices.

If you have further questions or need clarification on any of the above information please ask. Thank you.