Elite Health & Fitness
512 Main Street
P.O. Box 6358
Williston, ND 58802-6358
(701) 774-0320

Physical Therapy Clinic
PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Birth Date: _____

Preferred Name: _____ Sex: M F

SSN: _____ Primary Care Dr.: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (where you would like your bill to go.) ☐ If same as above.

Home Phone: _____ Cell Phone: _____

Email Address: _____

How would you like your appointment reminders? Call / Text / Email

Do you have more than one insurance? _____

What insurance pays primary? _____ What insurance pays secondary? _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: _____

INSURANCE HOLDER INFORMATION ☐ If same as above.

Name: _____ Birth Date: _____

SSN: _____ Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____

GUARANTOR INFORMATION The person responsible for payment of bills. ☐ If same as above.

Name: _____ Birth Date: _____

SSN: _____ Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____

☐ **Check here if your visit is due to a JOB RELATED INJURY or AUTOMOBILE ACCIDENT**

On what date did the injury/accident occur? _____ **Claim #:** _____

Have you had prior physical therapy with this claim? Yes No

Patient Employer Name: _____ Employer Phone Number: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

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PATIENT MEDICAL HISTORY FORM

Name (last): _____ **(first):** _____ **Age:** _____

To ensure you receive a complete and thorough initial evaluation at Elite Health & Fitness, please provide us with the important background information on this form. If you do not understand a question, we will assist you. Thank you.

Do you have now or have you ever had any of the following?

- ☐ Allergies / Skin Sensitivity
- ☐ Asthma / Breathing Problems
- ☐ Balance or Gait Disturbance
- ☐ Bladder or Bowel Changes
- ☐ Cancer
- ☐ Diabetes
- ☐ Easy Bruising / Bleeding
- ☐ Fainting / Dizziness
- ☐ Headaches
- ☐ Heart Problems / Hypertension
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Problems
- ☐ Vision Problems

☐ Any other previous injury or illness that may affect current care _____

Surgical History

Please list all surgeries and corresponding dates: _____

_____

Family (Parents and Siblings) **Medical History:** _____

Personal Data

1. Work Status: ☐ Light Duty ☐ Off work ☐ Normal schedule ☐ Retired ☐ Disabled
2. Job position if still working: _____
3. Do you have a pacemaker? YES / NO
4. Do you smoke? YES / NO
5. Are you, or is there a chance you could be pregnant? YES / NO
6. Without wanting to, have you lost at least 20 lbs. in the past 6 months? YES / NO
7. Any language needs / barriers? _____
8. Please list all medications: _____
   ☐ See attached list
9. Do you feel safe in your home? YES / NO

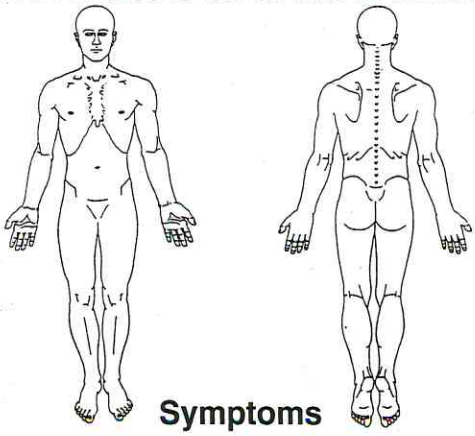
Current Condition

1. What are we treating you for? _____
2. Onset Injury or Pain _____
3. Is your current condition getting better, worse, or staying the same? _____
4. What are your physical goals? _____

Have you had any of the following tests or treatments for this problem?

- ☐ X-Ray
- ☐ CT Scan
- ☐ Bone Scan
- ☐ Arthrogram
- ☐ MRI
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Chiropractic
- ☐ Massage
- ☐ Other: _____

Please indicate the areas of concern



Symptoms

/// Numbness

XX Pain

Is the pain / numbness: ☐ constant ☐ intermittent

_____
Patient Signature Date

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HIPAA POLICY AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirement officially began on April 14, 2003. Many of the policies have been our practice for years. This is an abbreviated version, however the complete text is available in our offices or on the U.S. Department of Health and Human Services web site: www.hhs.gov.

HIPAA states that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office medical services.

Your information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers if desired, laboratories and health insurance payers as is necessary and appropriate for your care.

Our Electronic Medical Record (EMR) is secure and personal information is encrypted to insure confidentiality. General information which does not include any client identifiers may be used in retrospective studies. However, studies requiring any personal identifiers will require your approval and consent.

It is the policy of this office to remind clients of their appointment. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

We agree to provide clients with access to their records in accordance with state and federal laws. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the client. You have the right to request restrictions in the use of your protected health information as the law permits. Your confidential information will not be sold for any reason.

Your signature will indicate that you have read the HIPAA information and consent to the guidelines set forth in the Act.

Signature: _____ **Date:** _____

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Provider: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the HIPAA Privacy Notice.

_____

(PRINTED LEGAL NAME)

Sign: _____ _____

Patient or Personal Representative Date

Minor/Legal Representative

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient, in addition to copies of proper legal forms.

I authorize Elite Health & Fitness to give information when requested to: (list relationship)

First Name: _____ Last Name: _____

Relationship: _____

Type of information to be released: Medical _____ Billing _____

Based on this release, billing information may be given verbally, electronically, or in printed form. Medical information will be verbal only. I understand that when my information is released as a result of this authorization it is no longer protected by the federal privacy standards.

Elite Health & Fitness
501 Main Street – PO Box 6358
Williston, ND 58801
Phone: 701-774-0320
Fax: 701-774-0337

Elite
Insurance Disclaimer

Effective: August 1st, 2019

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we urge you, the patient, to please check with YOUR insurance company regarding your coverage.

It is YOUR responsibility to know YOUR coverage and its limitations including:

- Your number of visits
- Your copay/co-insurance
- Your deductible
- Your Network (In or Out)

Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember that your insurance policy is between you and your insurance company. If you have a co-payment it must be made at the time of service.

_____ _____

Patient or responsible party's signature Date

_____ _____

Witness (Elite Employee) Date

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Williston, ND 58801

Phone: 701-774-0320
Fax: 701-774-0337
Website: www.elitehealth.org

OVER ->

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Tel: (701) 774-0320
Fax: (701) 774-0337
Contact: cknodle@elitehealth.org
Web: www.elitehealth.org

Cancellation & No Show Policy

Cancellation Policy: You must notify Elite of an appointment cancelation 2 hours prior to your scheduled visit. Leaving a voicemail is an acceptable cancellation as long as it meets the cancellation window requirements. Failure to cancel within these requirements will result in your appointment counted as a "No Show". **Initial:** _____

No Show Policy: Accumulation of 3 or more "No Shows" will result in any and all additional appointments being canceled and re-assigned to another patient. You will not be billed for the appointments Elite cancels. In the event your appointments are canceled Elite will notify you via phone call. **Initial:** _____

No Show Penalty: There will be a $35 fee assessed to all No Shows. No Show fees will show up on your next billing cycle. **Initial:** _____

Signature: _____

Print: _____

Date: ____/____/____

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Physical Therapy Clinic

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Elite Health and Fitness/Specialty Clinics Inc. (hereinafter Elite), we use a variety of procedures and modalities to help us try and improve your condition. As with all forms of medical treatment, there are risks involved with physical therapy. We cannot always accurately predict your response to a certain procedure or modality. We cannot guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or aggravate previously existing conditions. You have the right to ask your physical therapist/practitioner what type of treatment he or she is planning based on your evaluation, diagnosis, and symptoms. You may also discuss with your therapist what the potential risks and benefits of treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Elite is authorized to release or request all or part of the patient's medical record to or from healthcare providers involved in care. Elite is further authorized to release such information as may be necessary or required for statistical reporting, healthcare review, accreditation purposes, or as required by law. It is understood that a photocopy of this form is a valid authorization for release.

Elite is authorized to release all or part of the patient's medical record to any person or corporation which is or may be liable for any part of Elite's charges. It is understood that a photocopy of this form is a valid authorization for release.

I hereby authorize payment of any insurance benefits arising from policies insuring the patient, or any party liable to the patient, directly to Elite and the attending providers, subject to the rules on coordination of benefits.

Cancellation/ No Show Policy for appointments: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel the appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not canceled 2 hours before hand, and you do not attend, you will be charged a $35 fee; this will most likely not be covered by your insurance company.

Elite is hereby released from any responsibility for valuables, monetary or sentimental, which the patient has or may acquire during this period of care. Elite specifically does not assume responsibility for the loss of the patient's personal articles.

I acknowledge receipt of Elite's Notice of Privacy Practices on the date indicated above. I have been offered and/or read and understand the information regarding Elite Health & Fitness's Financial Policy and consent to the guidelines within.

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and agree to proceed with treatment and accept the terms of this document.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Elite Health & Fitness. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Patient or Authorized Party Signature

Witness

Date