Elite Health & Fitness
512 Main Street
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Williston, ND 58802-6358
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## *Therapy Services*
# *PATIENT MEDICAL HISTORY FORM*

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

To ensure you receive a complete and thorough initial evaluation at Elite Health & Fitness Therapy Services, please provide us with the important background information on this form. If you do not understand a question, your therapist 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) **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: _____

   _____
9. Do you feel safe in your home? YES / NO

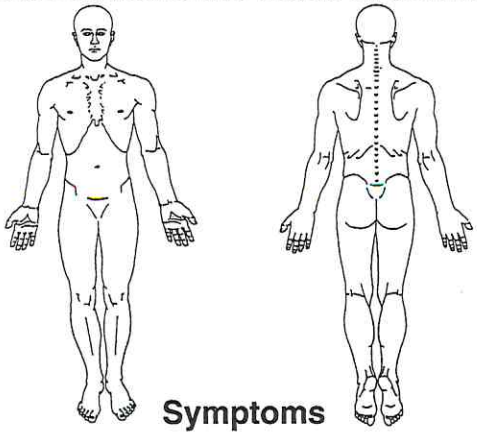
## Current Condition

1. Type of injury / condition: _____
2. Onset / Injury date: _____
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

# PATIENT REGISTRATION FORM

Patient Name: _____

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: Male / Female Married/Single/Divorced/Widow

Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____ E-mail Address: _____

Cell Phone: (_____) _____

Race: ( )African American ( )Asian ( )Caucasian ( )Hispanic ( )Native American ( )Declined to Disclose ( )Other

Ethnicity: ( )Cuban ( )Hispanic or Latino ( )Mexican ( )Not Hispanic or Latino ( )Puerto Rican ( )Declined to Disclose ( )Unknown

Employer Name: _____Employer Phone Number: (_____) _____

Employer Address: _____
(Street) (City/State/Zip)

Primary Care Physician: _____
(Name)

**Person responsible for bill or parent (Complete only if different from patient)**

Guarantor Name: _____ SS #: _____ - _____ - _____

Relationship to Patient: ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____

Phone Number: (_____) _____

Employer Name: _____

Employer Phone Number: (_____) _____

Employer Address: _____
(Street) (City/State/Zip)

**Who to call for an emergency:**

Name: _____ Address: _____

Home Phone: (_____) _____Work Phone: (_____) _____

Relationship: _____

(over)

*IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?*
*YES_____ NO_____*

*IF YES, PLEASE NOTIFY THE RECEPTIONIST*

*INJURY/ACCIDENT DATE_____*

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. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

HIPAA Release of information
AUTHORIZATION FORM

I, _____ hereby authorize Elite Health & Fitness and its affiliates, its employees and agents (collectively Elite), to release to _____ [Insert full name of person/ _____ my personal health information maintained by Elite (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

_____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of 1 Year [INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]

I understand that I have a right to revoke this authorization by providing written notice to Elite. However, this authorization may not be revoked if Elite, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date: _____

If applicable, Legal Representatives sign below:
*By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.*

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

## Please Read and Initial Both Items Below

I have been offered information regarding HIPPA and/or have read and understand the information and consent to the guidelines within _____

I have been offered and read and understand the information regarding Elite Health & Fitness's Financial Policy and consent to the guidelines within _____

Elite Health & Fitness

## 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 or 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.

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 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.

_____ _____

Patient or Authorized Party Signature Witness Date