NAME: _____

DOB: _____

Patient Health History and Information

Age: _____ **Height:** _____ **Weight:**_____ **Sex:** M F

Dominant hand: R L **Could you be or are you pregnant:** Yes No

Reason for Therapy:_____

Date of injury/onset of symptoms: ___/___/___ **Surgery for this condition**: Yes/ No Date ___/___/___ Type _____

Please describe how your injury/problem occurred:_____

Please list any treatment you have received for this condition(ie. PT, chiro)_____

For this condition have you had any of the following? EMG___/___/___ X-ray ___/___/___ MRI / CT scan ___/___/___

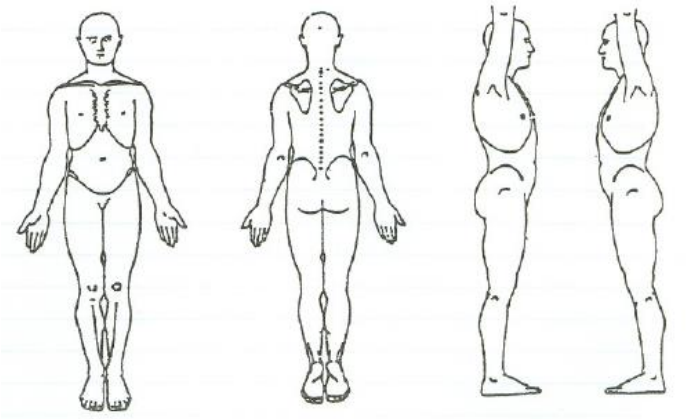
Injection: type: _____ ___/___/___ Other:_____ ___/___/___

Have you had this problem before? Y/N When?_____ What kind of treatment?_____

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain **//**= Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing		Increasing		Staying the same	
Weakness	Giving way	Throbbing	Other:_____		

What makes your symptoms worse? _____

What makes your symptoms better? _____

Limitations due to your current problem:_____

____Laying down	____Bending	____Turning Head	____Sleep/Awake from Pain
____Sit to stand	____Work	____Sitting	____Self Care/Hygiene
____Up/Down Stairs	____Driving	____Walking	____Home activities
____Squatting/Lifting	____Swallowing	____Standing	____Repetitive activities
____Looking overhead	____Talk/Chew/Yawn/All	____Reaching	____Sport/Recreation
____Taking a breath	____ Cough/sneeze pain	____Childcare	

What are your goals for therapy? (Two things you want to be able to do again or do better)

1._____ **2.** _____

How did you hear about Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

NAME: _____ DOB: _____

GENERAL HEALTH HISTORY:

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other:_____	Yes	No
Headaches	Yes	No			

Have you had any falls or near falls in the past year? Yes/No. If yes, how many _____

Rate your overall health: Excellent Good Average Poor **Living Situation:** Alone Spouse Family Others

Do you exercise? Yes / No _____x/week Type:_____ **Do you smoke?** Yes/ No

Do you drink caffeinated beverages? Yes/No ___/week

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Anxiety	Self	Family	No	Thyroid problems	Self	Family	No
Cancer	Self	Family	No	Epilepsy/dizziness	Self	Family	No
High Cholesterol	Self	Family	No	Tuberculosis	Self	Family	No
High blood pressure	Self	Family	No	Anemia/blood disorder	Self	Family	No
Heart trouble/angina	Self	Family	No	Multiple Sclerosis	Self	Family	No
Diabetes	Self	Family	No	Circular/vascular problems	Self	Family	No
Stroke	Self	Family	No	Chemical Dependency	Self	Family	No
Osteoporosis	Self	Family	No	Pacemaker/metal implants	Self	Family	No
Osteoarthritis	Self	Family	No	AIDS/HIV	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Hepatitis	Self	Family	No
Depression	Self	Family	No	Bladder/bowel problems	Self	Family	No
Headaches	Self	Family	No				
COVID-19	Self	Family	No	Other:_____			

SURGICAL HISTORY (please list any surgeries): _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed, or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical/occupational therapy treatment: No _____ Yes _____

WORK HISTORY:

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Workdays missed:** _____

QRC and/or Adjuster (if you have one)**:**_____

Patient Signature: _____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

OSI Physical Therapy

An Associate of Therapy Partners, Inc.

Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:		Patient updated:	Date:
Therapist reviewed:	Date:		Therapist reviewed:	Date:

AUTHORIZATION TO TREAT: I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize OSI to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED.** **Initials _____**

PAYMENT AUTHORIZATION: I understand that all balances designated as 'the patient's responsibility' such as co-insurances, co-pays and deductibles are due and payable to OSI. I agree to pay the charges for the care & treatment rendered to me that are not coved by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that OSI may be provided with information about my insurance coverage, and that on occasion OSI may share some of this information with me. However, I understand OSI is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. *** **This is not a guarantee of benefits. *** ** **Initials _____**

We have contacted your insurance company and they reported the following information.

Primary Deductible $_____ Co-Insurance %_____ Co-Pay $_____ Visit Limit _____ Prior Authorization Yes or No

Secondary Deductible $_____ Co-Insurance %_____ Co-Pay $_____ Visit Limit _____ Prior Authorization Yes or No

If your deductible has not been met or you have a balance, we would be happy to receive payment for your therapy at each visit.

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to OSI for all services delivered; if I am paid directly I will promptly pay OSI all monies paid to me. **Initials _____**

HIPAA PRIVACY POLICY: My signature below indicates that I have been offered the Notice of Privacy Practices for OSI. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to OSI to release any of my protected healthcare information. **Initials _____**

CANCEL/NO SHOW POLICY: We ask a 24 hour notice, if possible, prior to your scheduled appointment if you need to cancel. OSI reserves the right to only allow you "Same Day Scheduling" if 3 or more, less than 24 hour cancel or no shows. **Initials _____**

RECORD RELEASE: I am aware that OSI may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **Initials _____**

Appt. Reminders: As a service to patients, we provide appointment reminders via Text or Email. Other calls for (ie. Weather closure) may be placed leaving voice messages. By providing your number and email you consent to receive such calls.

Mobile Number_____Phone Carrier_____Email_____**Initials _____**

Date: _____Print Patient's Name: _____

Patient/Guardian Signature: _____Relationship to Patient_____

Patient Name: _____DOB: _____

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days have you received any type of Home Health Services, therapy from a home health care agency, transitional care facility, or nursing home?: YES NO If YES, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information.

Initials _____

MN SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring.

Initials _____

PAYMENT AUTHORIZATION – PROMPT PAY: Services will not be billed to your insurance company and/or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $150.00 or $200.00 follow-ups are $100.00 or $130.00. If a supply or orthotic is issued, an additional charge will be added. I do not want my services billed to any insurance, and I will not do so myself.

Initials _____

TELEHEALTH/E-VISIT: I approve the possibility of being seen by a clinician via telehealth for a portion of my care

Initials _____

Consent to treat during COVID-19 pandemic

COVID-19 has been declared a worldwide pandemic as it is extremely contagious and is believed to spread by person-to-person contact. As a result, Federal and State health agencies recommend social distancing. The staff at OSI Physical Therapy are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with in person physical therapy treatment.

By signing this form, I understand:

1. I am opting for in person physical therapy treatment during a COVID-19 worldwide pandemic.
2. I have the option to complete my physical therapy visit remotely via videoconferencing service at the same rate as an in person visit.
3. Despite all appropriate precautionary measure, it is possible to have exposure to COVID-19 during the physical therapy session and I assume this risk.
4. Even if I have tested negative for COVID-19, the test may fail to detect the virus or I may have contracted COVID-19 after the test was administered.
5. It is my duty to report to my physical therapist any symptoms of illness, travel outside of the U.S.A or close contact with someone testing positive for COVID-19 in the past 14 days. In this situation, I will not enter the OSI Physical Therapy office and must instead cancel my appointment or schedule a virtual physical therapy visit.
6. If I have had an in person physical therapy visit within 14 days of testing positive for COVID-19, I will contact OSI Physical Therapy to notify the staff immediately.
7. The COVID-19 pandemic may cause additional risks, some or many of which may not currently be known at this time.
8. My healthcare provider reserves the right to cancel or reschedule in-clinic appointments as needed.

I acknowledge and assume the risks listed above and I give my express permission for all the staff at OSI Physical Therapy to proceed with the treatment indicated. I have read and understand the information above. I hereby provide my informed consent to OSI Physical Therapy to receive in person physical therapy treatment.

_____ _____ _____

Patient/Guardian Full Name *Patient/Guardian Signature* *Date*

Relationship if applicable: _____

5/1/2022

Health Insurance Benefits/Coverage/Authorizations DISCLAIMER

As a courtesy OSI Physical Therapy will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware, this is only "A **QUOTE** of Benefits/Authorizations." **We cannot guarantee payment to verify that definite eligibility of benefits conveyed to us to you by your carrier will be accurate or complete. Payments of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service.**

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Our office will make every effort to bill your insurance in a timely manner. If your carrier determines that a particular service is not reasonable and necessary, or that a particular service is not covered under your plan, your insurer will deny payment for that service and it will become your responsibility.

We recommend you to be familiar with and verify your benefits with your insurance company prior to your services at OSI Physical Therapy. Please be aware, that even then, it is still not a guarantee of benefits or payment.

Thank You

NOTICE OF PRIVACY PRACTICES
Joint Notice of Privacy Practices
We Care About Your Privacy

To Our Patients

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This document is adapted from U.S. Department of Health and Human Services Model Notice of Privacy Practices that includes an overlay of Minnesota's additional legal requirements. It is intended to be adapted by health care providers to suit their individual needs. Please review it carefully. ***Minnesota's legal requirements*** **are in** ***italic text and bolded***

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

This Notice of Privacy is a joint notice that applies to:

All member practices of the Therapy Partners network. What is Therapy Partners? The practice and providers where you are receiving treatment, is a member practice of Therapy Partners. They receive services and support for administration, billing and collections, care management guidance, compliance, outcome measurement, provider credentialing, improvement activities, and share risk in value-based payment arrangements with certain insurers. A complete list of the member practices can be found at the bottom on this notice (collectively referred to in this Notice as "we", "our", or "us").

How do we typically use or share your health information?

We typically use or share your health information in the following ways. We need your ***consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency.***

1. **Treat you:** We can use your health information and share it with other professionals who are treating you *only if we have your consent.* ***We can only release your health records to health care facilities and providers outside our network without your consent if it is an emergency and you are unable to provide consent due to the nature of the emergency. We may also share your health information with a provider in our network.***
2. **Run our organization:** We use and share your health information to manage our operations and improve the quality of your care, in which the providers and practices participate and may contact you when necessary. ***We are required to obtain your consent before we release your health records to other providers outside our organization for their own health care operations.***
3. **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities ***only if we obtain your consent.***

Use and disclosure of your health information in certain special circumstances

We are allowed or required to share your information in other ways--- usually in ways that contribute to the public good, such as public health and research We have to meet many conditions in the law before we can share your information for these purposes.

1. **Help with public health and safety issues**
   - We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

2. **Do research:** We can use or share your information for health research **i*f you do not object.***
3. **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
4. **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations ***only with your consent.***
5. **Work with a medical examiner or coroner:** We can share health information with a coroner and medical examiner when an individual dies ***We need consent to share information with a funeral director.***
6. **Address workers' compensation, law enforcement, and other government requests**
   - For workers' compensation claims
   - For law enforcement purposes or ***with a law enforcement official with your consent, unless required by law.***
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services ***with your consent, unless required by law.***
7. **Respond to Legal Actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena (NOTE TO PROVIDER: Minnesota may require a court order; however, providers should consult with legal counsel upon receipt of these types of documents)
8. **Other State Law:** The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures ***"In Minnesota, we need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent."***

<u>When it comes to your health information, you have certain rights.</u>

1. **Receive an electronic or paper copy of your medical record**
   - You can ask to see or copy an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health information within a reasonable time
   - /***f you ask to see or receive a copy of your record for purposes of reviewing current medical care, we may not charge you a fee.***
   - ***If you request copies of your patient records of past medical care, or for certain appeals, we may charge you specified fees.***
2. **Ask us to correct your medical record**
   - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
   - We may say "no" to your request, but we'll tell you why in writing within 60 days
3. **Request for us to contact you confidentially**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say “yes” to all reasonable requests

4. Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations (TPO). We are not required to agree to your request, and we may say “no” if it would affect your care
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information
- ***Minnesota Law requires consent for disclosure of treatment, payment, or operations information.***

5. Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make) We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

6. Get a copy of this privacy notice

- We will offer you a copy of this notice upon your initial visit and any time after, if we change the contents of the notice.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
- We will provide you with a paper copy promptly

7. File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this document
- You can file a complaint with the U S Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S W Washington, D C 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint

<u>For certain health information, you can tell us your choices about what we share.</u>

1. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us NOT to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

2. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Minnesota Law also requires consent for most other sharing purposes.

3. In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Responsibilities

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. Per HIPAA no later than sixty (60) days from the date of discovery.
3. We must follow the duties and privacy practices described in this notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
5. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: May17, 2021
HIPAA Compliance: HIPAA Privacy Office, Therapy Partners, Inc., 7581 9th Street N., Suite 100, Oakdale, MN 55128
HIPAA Officer Contact Phone Number: 651-747-4350

ENTITIES SUBJECT TO THE JOINT NOTICE OF PRIVACY PRACTICES

Achieve Health & Wellness, LLC – Apple Valley
AGADA Physical Therapy & Integrative Health Center – Wayzata
Creekside Physical Therapy – Edina
Crossover Physical Therapy – St. Michael
Engage Physical Therapy and Wellness, LLC – Excelsior
Ethos Performance, LLC - Hudson
In Motion Therapy – Duluth
Lake Area Therapy Services

- Lake Area Therapy Services – Moose Lake
- Lake Area Therapy Services – Cromwell

Living Well Therapy

- Living Well Therapy – Duluth
- Living Well Therapy – Floodwood
- Living Well Therapy – Tower

Motion, LLC

- Motion, LLC – St. Paul
- Motion, LLC – Minnetonka
- Motion, LLC – St. Louis Park
- Motion, LLC – Eden Prairie

Minnesota Sport & Spine Rehabilitation Inc

- Minnesota Sport & Spine Rehabilitation Inc – Burnsville
- Minnesota Sport & Spine Rehabilitation Inc – St. Paul

Optivus Physical Therapy – Mankato
Orthopaedic Sports, Inc

- Orthopaedic Sports, Inc – Stillwater
- Orthopaedic Sports, Inc – West St. Paul
- Orthopaedic Sports, Inc – Shoreview
- Orthopaedic Sports, Inc – White Bear Lake
- Orthopaedic Sports, Inc – Forest Lake
- Orthopaedic Sports, Inc – Somerset
- Orthopaedic Sports, Inc – 3M Center
- Orthopaedic Sports, Inc – Maplewood
- Orthopaedic Sports, Inc – Oakdale

PRO Therapy

- PRO Therapy – Coon Rapids
- PRO Therapy – Minneapolis

Progressive Care Therapy, LLC

- Progressive Care Therapy, LLC – Majestic Pines, Grand Rapids
- Progressive Care Therapy, LLC – Grand Living, Grand Rapids
- Progressive Care Therapy, LLC – Detroit Lakes

Relief Physical Therapy and Wellness – Ham Lake

SitFit, LLC – Richfield
Thrive Physical Therapy – Chanhassen
Wieber Physical Therapy

- Wieber Physical Therapy – Faribault
- Wieber Physical Therapy – Northfield

Zumbrota Sport & Spine Physical Therapy – Zumbrota