



Today's Date ____/____/____

Full Name _____ Date of Birth ____/____/____ Gender ____M ____F

Social Security # _____ Email * _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient Employer _____ Job Title _____

Are you presently working? Yes No

Insurance Primary Enrollee Name & Relationship (who pays for the insurance plan – self, mom, dad, spouse etc):

Name _____ Relationship _____

Insurance Primary Enrollee Birthdate ____/____/____

Address of Primary Enrollee: _____ City _____ State _____ Zip _____

If Patient is a student: Name of School _____ Grade _____

College Students: Student Local Address _____

I authorize employees of Sport & Spine Physical Therapy to discuss my case, as necessary, with the following persons:

Spouse (Name): _____ Father (Name): _____

Mother (Name): _____ Other (Name): _____

If insurance primary enrollee is other than patient, your signature authorizes billing discussions with this party.

*By providing your email address, you are agreeing to receive electronic information from Sport & Spine P.T.

CONSENT TO PHYSICAL THERAPY

- 1. CONSENT TO TREATMENT:** I consent to rehabilitation and related services at Sport & Spine Physical Therapy of Winona. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. Graston Technique® (GT) is an instrument-assisted variation of traditional cross fiber or transverse friction massage. GT is a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated. Graston Technique® may produce the following: (1) Local discomfort during the treatment. (2) Reddening of the skin. (3) Superficial tissue bruising. (4) Post treatment soreness.
- 2. TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment here, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.
- 3. LIABILITY:** I know and agree that Sport & Spine Physical Therapy of Winona is not responsible for loss or damage to personal valuables.
- 4. AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to Sport & Spine Physical Therapy of Winona and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices, of which a copy has been offered to me. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

I certify that all the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

My initials on all subsequent pages serves as proof of truth and authorization provided by me.

1512 Service Drive
Winona, MN 55987
Phone: 507-474-6900 Fax: 507-474-0502



MEDICAL HISTORY FORM

Patient's Name _____

Today's Date ____/____/____

Height ____ft Weight ____lbs Sports/Recreational Activities/Hobbies: _____

Reason for visit _____ Date of Injury/Onset _____

Have you experienced these symptoms before? Yes No (If yes, when?) _____

Indicate how you sustained this condition:

- Work related injury Athletic/Recreation Injury Cause Unknown
 Motor Vehicle Accident - State _____ Injury related to lifting Recurrence of prior condition

Have you had surgery related to this condition? Yes No

If yes, what type of surgery? _____ Date of Surgery _____

Have you fallen down in the last year? Yes No

If yes, how many times? _____ Were you injured? Yes No

Are you currently taking any medication/vitamins/herbal supplements? Yes No

If yes, please list _____

Medicare Patients only, please provide a list showing name, dosage, frequency and route of administration for each medication you are currently taking.

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- Allergies _____ Depression Kidney Problems
 Anxiety Diabetes Liver/Gallbladder Problems
 Arthritis Dizziness/Fainting Metal Implants
 Asthma Headaches MRSA
 Bowel/Bladder Problems Head Injury Nausea/vomiting
 Cancer _____ Heart Attack Osteoporosis/Osteopenia
 Cervical Trauma/Whiplash Heart Disease Pacemaker
 Chest Pain/Angina Hepatitis Recent Fracture
 COPD Hernia Ringing in your ears
 CVA/Stroke/TIA High Blood Pressure Seizures
 Infectious Disease Skin Abnormalities

If you answered "yes" to any of the above, please explain and give approximate dates: _____

Are you currently pregnant? Yes No

Do you smoke or chew tobacco products? Yes No

Initials: _____ Date: _____


Sport & Spine
Physical Therapy
Of Winona, Inc.
FINANCIAL POLICY

Thank you for choosing Sport & Spine Physical Therapy of Winona, Inc., as your Physical Therapy provider. We are committed to providing the best possible care for you. If you have medical insurance, we are committed to helping you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our payment policy.

Copay payments are due prior to or upon completion of each treatment visit. We accept: CASH, MASTERCARD, VISA, DISCOVER OR PERSONAL CHECKS. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

Insurance

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is NO GUARANTEE from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. In this event, we will mail you a statement and appreciate your prompt payment. We reserve the right to charge interest on balances that exceed 90 days.

Regarding insurance plans where we are a participating provider we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim.

Our fees are considered to fall within the acceptable range by most companies and we charge what is usual and customary for our area. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. These particular services, if any, are your responsibility.

Work Comp/Liability Cases

If this injury is work related and a Workers Compensation claim has been initiated, **we must have a claim number and address to remit the claim within 3 days of your initial visit.** If the claim number has not been received or your case is denied by Workers Compensation, then you are responsible for each visit.

Cancelled appointments or failure to attend appointments as defined by your Physical Therapist will be recorded and your Work Comp Adjuster will be notified.

Missed Appointments

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. When an appointment is cancelled, or is a “no-show”, it not only affects your therapy but also takes away an opportunity for another patient to attend therapy. It is our policy to reschedule any cancelled appointments for the same week at the time of your call.

Authorization

I give my permission to Sport & Spine Physical Therapy of Winona, Inc., to release information, verbal and written, from my medical record to my physician, insurance company, nurse, adjuster, case manager, attorney, employer, school, related healthcare provider or other assignees as it relates to my treatment.

I have read, understand, and agree to this Financial Policy

Initials: _____ Date: _____

Body Diagram

Instructions:

On the body diagram below, please indicate the location and type of sensation you are currently experiencing for today's visit.

XXX Pain

/////// Numbness

~~~~~ Tingling, Asleep, Abnormal

