

# WELCOME TO SAUNDERS THERAPY CENTERS

Please share how you heard about us: \_\_\_\_\_

## PATIENT INFORMATION

**Legal Name** Last, First, Middle Initial

**Date of Birth**

**Email Address**

**Mailing Address**

**City, State, Zip**

**Legal Sex (please check one)**  Female  Male

*While Saunders Therapy Centers recognizes a number of genders/sexes many insurance companies and legal entities unfortunately do not. Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing, & correspondence. If your preferred name and pronouns are different from these, please let us know.*

**Preferred Name:**

**Pronouns:**

**Referring Physician**

**Clinic Name & City**

**Clinic Phone**

## PATIENT PHONE NUMBERS

**Please provide at least one contact phone below:**

**Type (check one)**

**May we leave detailed voicemails?**

**Phone:**

Cell  Home  Work

Yes  No

**Phone:**

Cell  Home  Work

Yes  No

## INSURANCE INFORMATION

**Primary Insurance Company Name**

**Are you the primary insured on this plan?** \_\_\_Yes\_\_\_No

If No, please provide that person's information below:

**Member#**

**First, Last Name**

**Group # (OR Work Comp Claim#)**

**Date of Birth**

**Relationship**

**Secondary Insurance Company Name**

**Are you the primary insured on this plan?** \_\_\_Yes\_\_\_No

If No, please provide that person's information below:

**Member#**

**First, Last Name**

**Group#**

**Date of Birth**

**Relationship**

## WORKERS COMPENSATION AND MOTOR VEHICLE PATIENTS ONLY

**Date of Injury:**

**Employer Name:**

**Area of the Body Injured:**

**Social Security#: «SSN»**

**Employed**  Full time  Part time  Retired  Other

## IN CASE OF EMERGENCY

**Name**

**Contact #**

Cell Phone  Home  Work

## APPOINTMENT REMINDERS

Which contact number above should we use for your appointment reminders?  Cell  Home  Work

Please indicate if you would prefer appointment reminders by:  Phone Call or  Text Message

## NO-SHOW & LATE CANCELLATION POLICY

It is important that you understand our appointment cancellation and no-show policy. We encourage regular attendance in accordance with your plan of care you have established with your Physical Therapist. This will maximize your successful outcome.

You will receive an automated reminder 48 hours prior to your scheduled appointments. In an effort to accommodate all of our patients, we must enforce a cancellation and no-show policy. The appointments you make represent time set aside specifically for you.

- All cancellations must be made no later than 24 hours prior to the scheduled visit
- **All no-show or late cancellations (less than 24 hours notice) will be charged a \$35 fee.**
- All future appointments scheduled will be taken off the schedule after two consecutive no-shows or chronic cancellations.

Thank you for your consideration of our therapist's time and assisting us in ensuring we are able to make appointments available to other patients on waiting lists if you are unable to attend.

## CONSENT TO TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS

I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures.

I authorize the release of information obtained during evaluation or treatment required for payment purposes to my insurance company. I assign Saunders Therapy Centers the medical benefits to which I or my dependents are entitled under my health insurance. I understand that I am financially responsible for all charges including charges not covered by my insurance, and for any reasonable collection fees required to collect delinquent accounts.

I agree to receive information about my care by email or text. I have been given access to the notice of privacy practices.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Name: \_\_\_\_\_

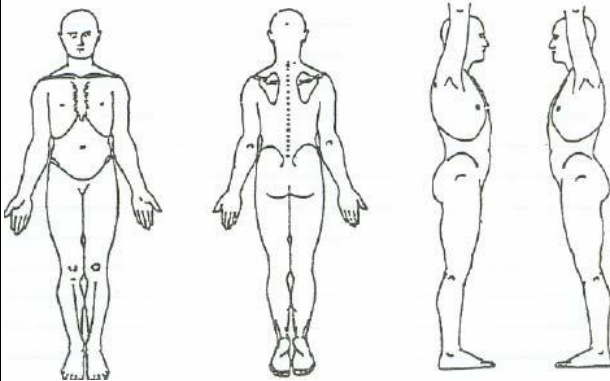
**PATIENT INFORMATION**

**Referring Physician:** «RefPrFName» «RefPrLName»      **Age:** \_\_\_\_\_      **Height:** \_\_\_\_\_      **Weight:** \_\_\_\_\_

- 1. Please indicate the date your symptoms began:**  
(Please indicate specific date if possible)  
\_\_\_\_/\_\_\_\_/\_\_\_\_
- 2. Are your symptoms related to any of the following (check all that apply):**  
 Motor Vehicle Accident     Sports Injury     Work Accident
- 3. Surgery Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Related to present problem, if applicable)

**4. Using the key below, indicate on the body diagrams where your symptoms are located:**

X=Pain    O=Tingling    // =Numbness



**Circle below indicating your pain at its lowest and highest levels:**

Lowest: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

Highest: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

**5. Since onset are your symptoms getting: (check one)**

- better     worse     not changing

**6. What relieves (R) or aggravates (A) your symptoms?**

- |                            |                         |                |
|----------------------------|-------------------------|----------------|
| ___ Sitting                | ___ Rest                | ___ Massage    |
| ___ Heat                   | ___ Standing            | ___ Medication |
| ___ Cold                   | ___ Walking             | ___ Nothing    |
| ___ Stretching             | ___ Exercise            | ___ Lying down |
| ___ Wearing a splint/brace | ___ Coughing / sneezing |                |
| ___ Other: _____           |                         |                |

**7. As the day progresses do your symptoms: (check one)**

- increase     decrease     stay the same

**8. Does pain wake you at night?**     Yes     No  
**If "yes" is it present:**  
 while lying still     when changing positions     both

**9. Do you have pain/stiffness getting out of bed in the morning?**     Yes     No

**10. Since your symptoms began have you had:**

- none
- fever / chills / nausea / vomiting
- any numbness in genital / anal area
- numbness / tingling / burning
- dizziness / fainting
- weakness
- unexplained weight change
- night sweats / pain
- problems with vision / hearing / speech
- any difficulty with bladder / bowel function
- headaches
- other \_\_\_\_\_

**11. Treatments previously received for this condition:**

- none
- medication
- Chiropractic
- Physical Therapy
- massage
- bracing / taping
- biofeedback
- TENS
- injection / acupuncture
- casting / immobilization
- hospitalization
- other \_\_\_\_\_

**12. Please check / list any other health care providers you are currently seeing for this condition:**     None

- MD \_\_\_\_\_
- Podiatrist
- Physical Therapist
- Dentist
- Chiropractor
- Other \_\_\_\_\_

**13. Please check if you had any of the following for this condition:**

- None
- CT scan / MRI
- EMG
- Other \_\_\_\_\_
- X-rays

## GENERAL HEALTH

Dominant hand (circle): L R

How would you rate your overall health?

Excellent  Good  Average  Fair  Poor

Are you pregnant?  No  Yes date due: \_\_/\_\_/\_\_

Apart from your daily activities, do you exercise or perform vigorous activity?

Not at all  Seldom  Occasionally  Regularly

Do you drink caffeinated beverages?

No  Yes \_\_\_\_ / day

Do you smoke?

No  Yes \_\_\_\_ packs / day

What is your stress level?

Low  Medium  High

## MEDICATION

Please list any prescription and/or over the counter medications you are currently taking (pain pills, injections, skin patches, aspirin, vitamins, etc.)

See attached list

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PAST / CURRENT MEDICAL HISTORY

Have you ever had / been diagnosed with any of the following conditions? (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> None                                     |  |
| <input type="checkbox"/> Cancer _____                             | <input type="checkbox"/> Chemical Dependency   |
| <input type="checkbox"/> Heart problems                           | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Pacemaker                                | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Stroke                                   | <input type="checkbox"/> Lung problems/asthma  |
| <input type="checkbox"/> Kidney problems                          | <input type="checkbox"/> Incontinence          |
| <input type="checkbox"/> Thyroid                                  | <input type="checkbox"/> Blood disorder/anemia |
| <input type="checkbox"/> Epilepsy / seizures / dizziness          | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Arthritis—OA/RA, osteopenia/osteoporosis | <input type="checkbox"/> Latex allergies       |
| <input type="checkbox"/> Head injury                              | <input type="checkbox"/> Fractures             |
| <input type="checkbox"/> Circulation/vascular problems            | <input type="checkbox"/> Stomach problems      |
| <input type="checkbox"/> Infectious disease                       | <input type="checkbox"/> Parkinson's           |
| <input type="checkbox"/> Spine problems / surgery                 | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> Other _____                              |  |
| <input type="checkbox"/> List any other surgeries _____           |  |

## FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis – OA/RA       |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Psychological condition |
| <input type="checkbox"/> High blood pressure |  |
| <input type="checkbox"/> Other _____         |  |

## LIVING SITUATION

What is your current living situation? (check all that apply)

- Live alone  
 Live with family members/others/caregiver  
 home/apartment/retirement complex(independent/assisted)

Mode of transportation: \_\_\_\_\_

Environment (barriers, obstacles):

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Stairs – railing    | <input type="checkbox"/> No stairs |
| <input type="checkbox"/> Stairs – no railing | <input type="checkbox"/> Elevator  |
| <input type="checkbox"/> Other _____         |                                    |

## WORK HISTORY

Occupation: \_\_\_\_\_

- |                                      |                                    |  |
|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Full time   | <input type="checkbox"/> Part time | <input type="checkbox"/> Unemployed    |
| <input type="checkbox"/> Retired     | <input type="checkbox"/> Student   | <input type="checkbox"/> Self employed |
| <input type="checkbox"/> Other _____ |                                    |  |

Physical activities at work:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Sitting      | <input type="checkbox"/> Driving                   |
| <input type="checkbox"/> Standing     | <input type="checkbox"/> Repetitive lifting        |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Heavy lifting             |
| <input type="checkbox"/> Phone use    | <input type="checkbox"/> Heavy equipment operation |

Current working status:

- Full duty  
 Restricted duty  Work days missed: \_\_\_\_\_

If not performing your normal activities at work, do you plan to return to your previous activity level?

Yes  No

If this is a Work Comp claim – Do you have a QRC?

Yes  No

Are you seeking disability or are you consulting an attorney for this condition?

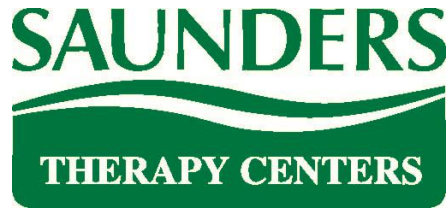
Yes  No

Patient / guardian signature: \_\_\_\_\_

M.D. follow up: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by therapist: \_\_\_\_\_

Date: \_\_\_\_\_



## 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 is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **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:

### **How We May Use and Disclose Health Information About You**

The following categories describe different ways that we use and disclose health information.

**For Treatment.** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to therapists, doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized, or at another provider's office.

**For Payment.** We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations.** We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

### **Use and Disclosure of Your Health Information in Certain Special Circumstances**

The following special circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To Federal officials for intelligence and national security activities authorized by law.
7. To correctional Institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### **Your Rights Regarding Your Health Information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to the clinic manager.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the clinic manager.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact the clinic manager.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the clinic manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

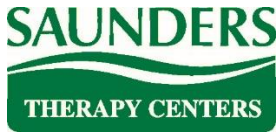
### **Acknowledgement:**

Please acknowledge your receipt of this Notice of Privacy Practices by providing your signature below:

Signature: \_\_\_\_\_

(Under 18, parent or guardian must sign)

Date: \_\_\_\_\_



## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

**INFORMATION TO BE RELEASED TO/FROM (circle one) SAUNDERS THERAPY CENTERS:**

- 6550 York Avenue South, Suite 520 Edina MN 55435  
Phone: 952-924-0199 Fax: 952-924-0314
- 2334 University Avenue, Suite 170 St. Paul, MN 55114  
Phone: 651-645-8083 Fax: 651-645-8078
- 10900 73<sup>rd</sup> Avenue North, Suite 110 Maple Grove, MN 55369  
Phone: 763-315-1296 Fax: 763-315-1297

**INFORMATION TO BE RELEASED FROM/TO (circle one):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to patient (Clinic, Attorney, Family, etc): \_\_\_\_\_

**INFORMATION TO BE RELEASED (check all that apply):**

- All Medical records on file.
- Specific treatment dates: from: \_\_\_\_\_ to: \_\_\_\_\_
- Other (please provide specifics) \_\_\_\_\_

**METHOD OF INFORMATION RELEASE (check all that apply):**

- Mail to the address checked above.
- Fax to the number checked above.
- Verbally discuss with a therapist located at the address checked above.

Unless specified otherwise below, this authorization will remain in effect for 1 year from the date of signature.

This request expires on \_\_\_\_\_ (date)

**PATIENT PRINT NAME:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

**Date:** \_\_\_\_\_