



## Marquette Rehabilitation & Sports Medicine Center

To our valued patients,

In order to speed up the registration process and begin your treatment as soon as possible, please complete the forms listed below and bring the proper documentation to your first visit. Forms can be obtained by contacting our office at (906) 226-0574 or online at <http://mqtrehab.com/patient>.

### **Forms**

- Patient Information Form
- Financial Policy
- Notice of Privacy Practices

### **Documentation**

- Drivers license or photo ID
- Insurance Card (Include insured's date of birth)

*We support both your health and financial needs. We are happy to arrange payment plans for patients with limited or no insurance. We accept cash, checks, Visa and MasterCard.*

Thank you,

Marquette Rehabilitation  
& Sports Medicine Center

# Marquette Rehabilitation & Sports Medicine Center Patient Information

PATIENT INFORMATION				Today's Date:    /    /	
First Name:		Last Name:		Middle Initial:	
Address:			City:		State:
Zip:	Birth date:    /    /		Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #:    -    -
Phone: (    )    -		Email:			Spouse:
<b>How did you hear about us?</b>					
<input type="checkbox"/> Dr.:		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Family <input type="checkbox"/> Friend	
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:				Work Phone (    )    -	
Ext.:					
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
CARE PROVIDER INFORMATION					
Referring Dr:				Referring Dr. Phone: (    )    -	
Regular Dr./PCP				Regular Dr./PCP Phone: (    )    -	
INSURANCE INFORMATION      ( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )					
Primary Insurance Name:					
Subscriber's Name (If different):					Birth date :    /    /
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:					Birth date :    /    /
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM      ( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )					
Insurance Name: <input type="checkbox"/> Auto :			<input type="checkbox"/> Labor & Industries:		
Adjuster/Claim Manager:				Phone:	
Ext.:					
Address:			City:		State:
Zip:	Claim #:		Accident Date:    /    /		Cause:
ATTORNEY INFORMATION					
Name:			Law Firm:		Phone: (    )    -
Address			City:		State:
Zip:					
IN CASE OF EMERGENCY					
Name of Local Friend or Relative:					
Relationship to Patient:			Home Phone: (    )    -		Work Phone: (    )    -

I authorize my insurance benefits be paid directly to Marquette Rehabilitation & Sports Medicine Center. I understand that I am financially responsible for any balance. I also authorize the release of any information required to process my claims.

Signature of Patient, Parent, Guardian, Personal Representative

DATE

# PAST MEDICAL HISTORY FORM

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

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
			Back	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION					
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Polio	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		
			_____		
			_____		
			_____		
LUNGS					
	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy before?  YES  NO Where: \_\_\_\_\_

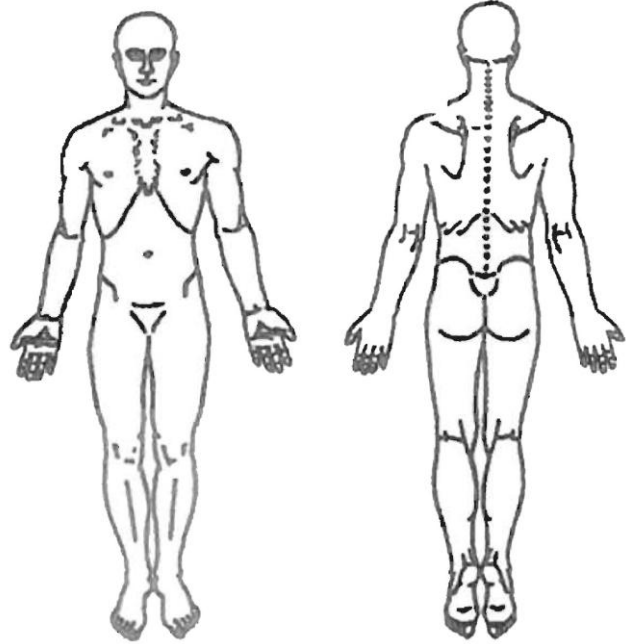
Signature of Patient, Parent, Guardian, Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

## Pain & Symptom Status Report

Using the symbols below, please draw at the type of pain you are having over the affected area.

- **M** (Ache)
- **-** (Burning)
- **O** (Numbness)
- **Δ** (Pins & Needles)
- **//** (Stabbing)
- **XX** (Other) \_\_\_\_\_



## Chief Complaint & Visual Analog Scale

Approximate date of when problem occurred: \_\_\_\_\_

My chief complaint is: \_\_\_\_\_

2<sup>nd</sup> Complaint: \_\_\_\_\_

3<sup>rd</sup> Complaint: \_\_\_\_\_

**Please indicate below your CURRENT level of pain** (0 = No Pain, 10 = Unbearable Pain)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

**Please indicate below your AT BEST level of pain** (0 = No Pain, 10 = Unbearable Pain)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

**Please indicate below your WORST level of pain** (0 = No Pain, 10 = Unbearable Pain)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Describe your injury/condition: \_\_\_\_\_

What are your goals for therapy?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



### PHYSICAL THERAPY FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, or Visa. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly mail the form along with the claim; however, you are responsible for completing the claim and making sure that you have signed it.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance co. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. **Medicare patients are responsible for the co-insurance unless being covered by a secondary insurance. Medicare recipients sign below.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

5. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by BWC, then you are responsible for each additional visit. We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form.
6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.
5. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule. Our office requires a 24-hour notice for cancellation of appointments.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

**PATIENT NAME (Print):** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Patient, Parent, Guardian, Personal Representative)



## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

### **PLEASE REVIEW THIS CAREFULLY AND SIGN AT THE BOTTOM**

**1. Uses and Disclosures:** We will use your Protected Health Information (PHI) for the purposes of treatment, payment and health care operations.

- **Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other Physical Therapists.
- **Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.
- **Health Care Operations** includes the utilizations of your records to monitor the quality of care being given at Marquette Rehabilitation & Sports Medicine Center.
- **Other Special Uses** Marquette Rehabilitation & Sports Medicine Center may use your PHI to remind you of appointments, send you a thank-you note or newsletter, or to request contributions to our charitable activities.

### **USES AND DISCLOSURES REQUIRED BY LAW**

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may also use and disclose health information about you to avert a serious threat to your health or safety or the health and safety of the public or others. If you are in the armed forces; we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for worker's compensation or to other similar programs that provide benefits for work-related injury or illness.

**YOUR AUTHORIZATION IS REQUIRED BEFORE YOUR PHI MAY BE USED OR DISCLOSED BY MARQUETTE REHABILITATION & SPORTS MEDICINE CENTER FOR ANY OTHER PURPOSE.**

### **2. Your Privacy Rights**

- **Restrictions** You have the right to request restrictions on how your PHI is used; however, we are not required to agree with your request. If we do agree, we must abide by your request.
- **Confidential Communications** You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

- **Access to PHI** You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.
- **Amendments** You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree and this will become part of your record. We may not amend parts of your medical record that we did not create.
- **Complaints** If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

**Our Duty to Protect Your Privacy**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

**Notice will take effect on July 13, 2009.**

If there is someone whom you would like us to release your information to, please fill in their name to the right:

_____	_____	_____
_____	_____	_____
(Name)	(Relationship)	(Phone)

**Please sign below to acknowledge that you were issued a copy of our Notice of Privacy Practices:**

**PATIENT NAME (Print):** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 (Patient, Parent, Guardian, Personal Representative)