corpore sano

Physical Therapy for Optimum Performance

SPORTS + ORTHOPEDIC PHYSICAL THERAPY
BICYCLE BIOMETRICS
SPORTS PERFORMANCE

ERIK MOEN, PT
KARI STUDLEY, PT, DPT
SUSIE FAGERHOLM, PT, DPT

Appointment Date	**Time**	**Therapist**

Patient Information

Last Name	First Name	Nick Name	Middle Intl

Address	City	State	Zip

Home Phone	Work Phone	Other Phone (Cell)

Date of Birth / /	Sex ☐ Male ☐ Female	Status S M D W	Email Address

Referring Physician	Referring Phone Number

Emergency Contact Information

Contact Name	Contact Number	Relationship to patient

Responsible Party
*Only complete the following if policy holder is not the patient

Last Name	First Name	Middle Intl

Address	City	State	Zip

Relationship to patient	Date of Birth / /	SS# - -

Primary Insurance Information

Insurance Company	Policy ID Number	Group Number

Claims Address PO BOX	City	State	Zip

Co-Pay $	Co-Insurance %	Deductible $ Met ☐ Yes ☐ No

Secondary Insurance Information

Insurance Company	Policy ID Number	Group Number

Claims Address PO BOX	City	State	Zip

Co-Pay $	Co-Insurance %	Deductible $ Met ☐ Yes ☐ No

Additional Questions

Date of Injury / /	Auto Related ☐ Yes ☐ No	Work Related ☐ Yes ☐ No	Accident Related ☐ Yes ☐ No

Diagnosis/Body Part

Have you had any prior Therapy this year? ☐ Yes ☐ No

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Last Name	First Name	DOB

Have you ever or are you presently being treated for any of the following conditions?

Allergies	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Headaches	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Seizures	Yes	No
Sexually Transmitted Disease	Yes	No
Ulcers	Yes	No

Have you or an immediate family member been told you have?

	You		**Family**	
Cancer	Yes	No	Yes	No
Chest Pain	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Osteoarthritis	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Rheumatoid arthritis	Yes	No	Yes	No
Stroke	Yes	No	Yes	No

Have you experienced any of the following in the past 3 months?

Change in your health	Yes	No
Changes in bowel or bladder function	Yes	No
Depression	Yes	No
Dizziness	Yes	No
Fever/Chills/Sweats	Yes	No
Nausea/Vomiting	Yes	No
Numbness or tingling	Yes	No
Shortness of breath	Yes	No
Stress	Yes	No
Unexplained weight changes	Yes	No
Upper Respiratory Infection	Yes	No
Urinary Tract Infection	Yes	No

Men:
Have you ever been diagnosed with Prostate Disease? Y___ N___

Women:
Are you pregnant or think you might be pregnant? Y___ N___

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things?
Yes No

Is this something with which you would like help? Yes Yes, not today No

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Last Name	First Name	DOB

Surgeries	
Year	**Reason**

Medications		**Allergies**	
Name of Drug/Supplement	Strength	Name	Reaction

Health Habits

Do you drink caffeinated beverages? Yes No
How many per day? _____
Do you drink alcohol? Yes No
How many per week? _____
Do you currently or have you previously used tobacco? Yes No
# of packs per day? _____
Do you exercise or participate in any hobbies or sports? Yes No
How many days a week? _____
How many minutes on average per day? _____

TOP 3 REASONS AND GOALS FOR YOUR VISIT TODAY:

1.
2.
3.

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Certification, Permission to treat
I certify that all information I have provided is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for proper treatment.

_____ _____
Signature Date

No-Shows and Late Cancels
I will reimburse Corpore Sano Physical Therapy a fee of $50.00 if I do not arrive for my previously scheduled treatment or cancel my treatment without a 24-Hour notice. I also understand that Corpore Sano Physical Therapy may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment.

_____ _____
Signature Date

Patient Financial Responsibility Statement
I hereby authorize my insurance benefits to be paid directly to Corpore Sano Physical Therapy and to release any information to process claims. I understand and certify I am financially responsible for non-covered services. ***Co-Payments are due at time of service**.
Returned check fee 25.00 per occurrence.

_____ _____
Signature Date

Acknowledgment of Receipt of Notice of Privacy Practices
I acknowledge receipt of a copy of the **Notice of Privacy Practices** of Corpore Sano.

_____ _____
Signature Date

OPTIONAL
I authorize Corpore Sano Physical Therapy to discuss my billing and/or medical condition with the following name(d) person(s). Please include the name(s) of persons with whom we are allowed to discuss your medical condition and/or billing information.

Name	Phone	Relationship
Name	Phone	Relationship

_____ _____
Signature Date

Last Name	First Name	DOB

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On the scales below, please circle the number which best represents the severity of your pain.
(0= no pain, 10= worst pain imaginable)

***Average* for the last 48 hours**

0 1 2 3 4 5 6 7 8 9 10

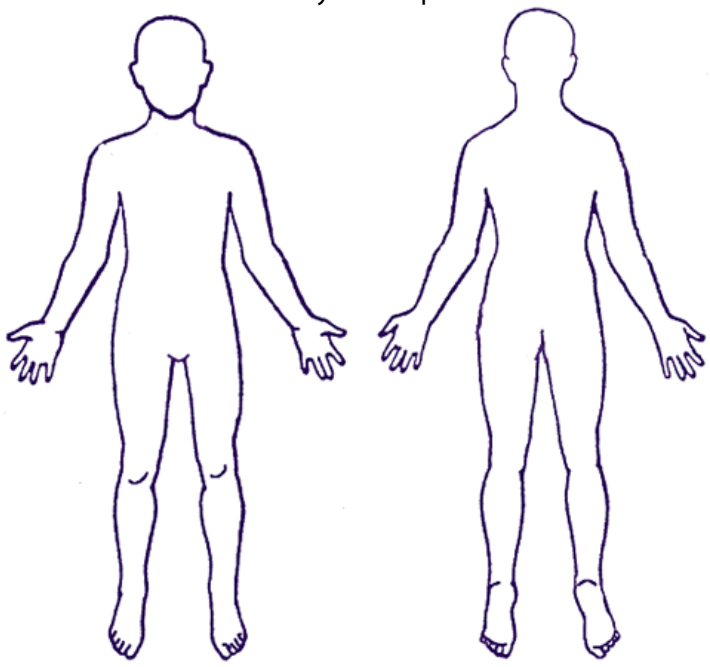
***Best* for the last 48 hours**

0 1 2 3 4 5 6 7 8 9 10

***Worst* for the last 48 hours**

0 1 2 3 4 5 6 7 8 9 10

Body Chart: Please mark the areas where you feel pain.



For Therapist:
+ / - Cough/Sneeze
+ / - Saddle Anesth
+ / - Bwl/Bldr Change
+ / - Numb/Ting.

Please circle the number below which best represents your overall average level of function.
(0= cannot do anything, 10= able to do everything)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms better?

1.

2.

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a results of your problem. List them below:

1.

2.

3.

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HIPAA Notice of Privacy Practices

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us, which we need to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Corpore Sano LLC, whether made by your physical therapists or any employee of Corpore Sano LLC. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public heath risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others

Your rights regarding Health Information about you:

- Rights to inspect and copy
- Right to amend
- Right to accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Changes to this Notice:
We reserve the right to change this notice. We will retain a copy of the current notice in our facility.

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Complaints:
If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location or department you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:
We will request that you sign a separate form acknowledging you have received a copy of this notice. The acknowledgement will become part of your records.