Sport & Spine
Physical Therapy
Of Winona, Inc.

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

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

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Revised 1/12/2017 4pages

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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

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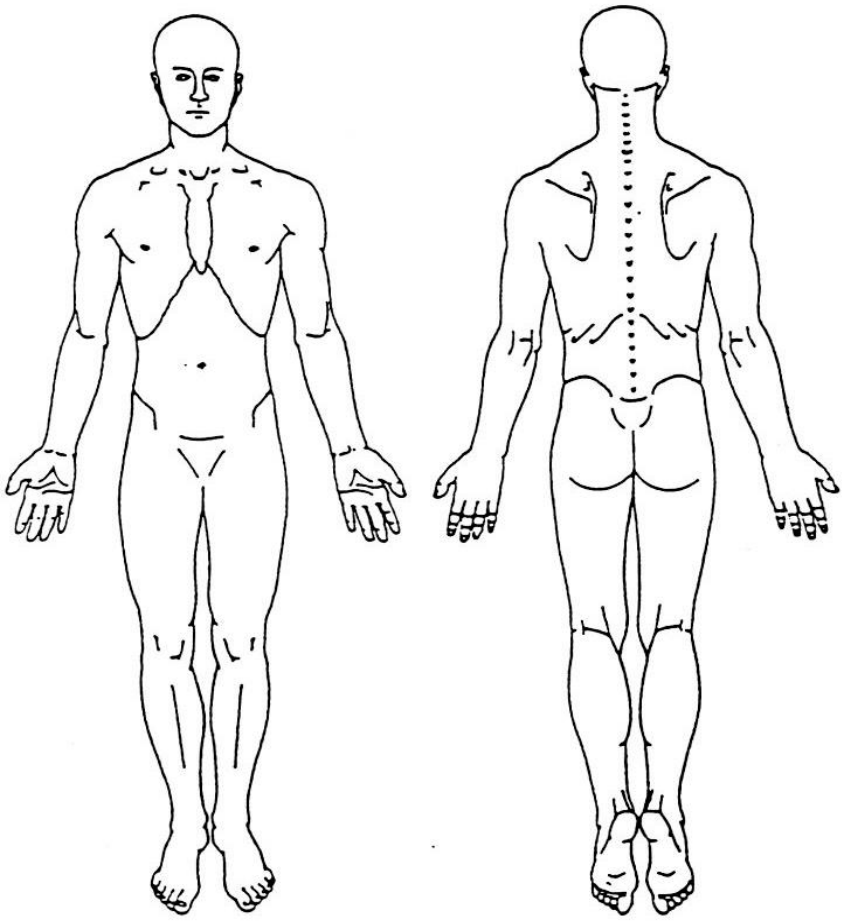
Body Diagram

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



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