Northern Life Wellness
Physical Therapy
Patient Information and History

Date: _____
File#_____
DR._____

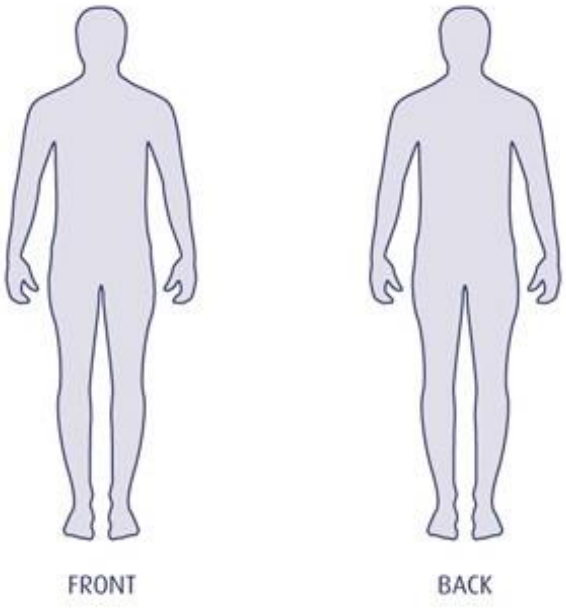
Section A: Patient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthday: _____ Age: _____ □ Male □ Female Social Security #: _____
Occupation: _____ Employer: _____
How were you referred to our office? _____
If you are a Northern Life Chiropractic patient, skip sections B and C.

Section B: Insurance **If previously filled out for chiropractic care, please leave this section blank.**
Who is responsible for this account? _____ Relationship to patient: _____
Insurance Company: _____ Insurance ID #: _____
Group/Claim #: _____ Is patient covered by additional insurance? □Yes □No
If yes, Insurance company: _____ Subscriber # and Name: _____
Subscriber DOB: _____ Group #: _____

Section C: Contact Information
Cell Phone: _____ (Parent's Name & Cell if Minor) _____
Home Phone: _____ Work Phone: _____ Ext: _____
Email: _____
In case of emergency please contact:
Name:_____ Relationship: _____ Phone #: _____

Section D: Patient Condition
What is your major symptom/problem? _____
When did your symptoms begin? _____
Have you had this problem before? _____
Is your condition getting progressively worse? □Yes □No Is this problem: □Constant □Comes and goes
Are you interested in □ Chiropractic Care? □ Massage Therapy?
Circle below the severity of your pain:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

Please circle/mark where you have pain



Health History:

Primary Care Physician: _____ Clinic's #: _____

Name & Location of Clinic: _____

Are you receiving other treatment for this condition? If yes, where? _____

Date of last: Physical Exam: _____ Spinal Exam: _____

List any Medications you are taking: _____

Vitamins/Herbs/Minerals: _____

Females: Are you pregnant: ☐Yes ☐No

Check any of the following conditions you have had:

- ☐ Aids/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/Shoulder pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Earache
- ☐ Ear Ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Headaches – Migraine
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated disk
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Irregular cycle
- ☐ Kidney problem
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus infections
- ☐ Strokes
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Venereal disease
- ☐ Vertigo/Dizziness
- ☐ Scoliosis

X I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary.

Date: _____Signature_____

Parent Signature (if minor): _____

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services, we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, the clinic is not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without our consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purpose; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request, we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the Compliance/Privacy Officer at: **Northern Life Wellness, 13955 W Preserve Blvd. Ste. 200, Burnsville, MN 55337 Phone: (952) 890-0804**

Consent/Authorization for Use and Disclosure of Protected Health Information

OUR PRIVACY PLEDGE: Northern Life Wellness is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the clinic may use or disclose your health care information include, but are not limited to:

- Another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about the clinic, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy

practices as described in that notice. The current notice, including the effective date, will be posted in the clinic and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, NORTHERN LIFE WELLNESS WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD-PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial Here

[ ] I acknowledge receipt of Northern Life Wellness's Notice of Privacy Practices

By signing below, I give consent to Northern Life Wellness clinicians or staff to disclose my personal health information.

_____	_____
Printed Name	**Parent or Guardian**
_____	_____
Signature	**Date**

Professional Fee Schedule

Usual and Customary Physical Therapy Fees

Consultation	No Charge	Electronic Muscle Stimulation (per unit)	$40
Evaluation	$170-210	Neuromuscular Re-education (per unit)	$70
Re-evaluation	$97	Manual Therapy Techniques (per unit)	$55
Hot/cold packs	$35	Therapeutic Activities (per unit)	$58
Gait Training (per unit)	$65	Therapeutic Exercises (per unit)	$70
Traction	$40	Ultrasound (per unit)	$40

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can. A detailed outline of services charges can be provided upon request.

PLAN 1: GROUP INSURANCE

If you have insurance which covers physical therapy, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you,

you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment. Please know that we will bill the insurance company for all the services provided including but not limited to extremity adjustment, traction, neurological re-education, and soft tissue therapies. If you have questions regarding any of your billing please ask.

PLAN 2: HEALTH CARE MADE AFFORDABLE (HCMA)/CASH

For those patients who qualify, we offer discounted cash agreements on a monthly block basis. Please ask for details separate to this professional fee schedule. Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. Discontinuing care before completing the agreed upon corrective or wellness care plan will cause your plan to be prorated at our regular rates for all visits from the beginning of care.

PLAN 3: WORKERS COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

Insurance verification and authorization is not a guarantee of payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I understand that I may be responsible for any balance that is not paid by insurance. I authorize the Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

I have read and understand all of the options available to me.

Date: _____Signature_____

Parent Signature (if patient is a minor): _____

PT 24-Hour Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. We know your time is valuable, and ours is too. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. To be respectful of your fellow patients, please call or text us as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call or text at least 24-hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

A cancellation is considered late when the appointment is cancelled less than 24-hours before the appointed time or a patient misses an appointment without cancelling. In either case, **starting November 1st, 2023, we will charge the patient a $40 cancellation/missed appointment fee.** Per the cancellation policy, we need a credit card on file for all PT patients.

Credit Card Authorization

I understand the cancellation policy above and authorize PIFF Holdings PC., DBA Northern Life to automatically charge my credit/debit card account in the event of a PT appointment cancellation within less than 24 hours. Initial _____

Patient Name: _____ Phone #: _____

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Account Number: _____

Exp. Date: _____ 3 Digit CID number on back of the card: _____

Cardholder Signature: _____ Date: _____

I have read and understand all of the options available to me.

Date: _____Signature_____

Parent Signature (if patient is a minor): _____

***Consent to Email or Text Usage for Appointment Reminders and Other Healthcare* Communications**

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications or billing information at that email or text address from the Practice.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the cell phone number indicated in Section C or currently on file.

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the email address indicated in Section C or currently on file.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

I understand that I have the ability to opt-out of such communications at any time by replying STOP. However, I acknowledge that doing so will no longer allow for me to receive text or email communications of any kind including appointment reminders.

I understand and to consent to all email and text communications outlined above.

Date: _____ Signature_____

Parent Signature (if patient is a minor): _____